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UNIVERSITY OF ALBERTA

Adaptive Change and Leadership in a Psychiatric Hospital

by

Mary Frances McHugh Abt ©

A thesis
submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

DEPARTMENT OF EDUCATIONAL ADMINISTRATION

Edmonton, Alberta
Fall 1992

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This thesis is dedicated to

Mrs. Ardyce James and
the late
Mr. Ted James

mentors and dear friends who, through their dedication and commitment to improving the care of the mentally ill in Alberta, inspired many of those with whom they came into contact to become advocates for the mentally ill

and the late
Mrs. Jenny Margetts

who, through her commitment to the principles of equality and justice, achieved the passage of Bill C-31. As a true warrior, Jenny did not stray from the right path and thousands of Native women walk proudly because one woman had a vision - equality for all Native people.

Abstract

The central purpose of this research was to investigate the process of adaptive change in one representative psychiatric hospital, with primary emphasis on the role of the Medical Superintendents as key facilitators of change in the organization. A case-study approach was adopted in examining selected critical events in the evolution of the hospital. The events include the elimination of mechanical restraints, 1928-1936; the introduction of tranquilizers, 1953-1957; and deinstitutionalization, 1967-1975.

Major data sources included interviews with staff employed at the hospital at the time of the selected critical events and examination of relevant documents, official records, and newspaper articles obtained from the hospital museum and the Public Archives of Alberta.

A conceptual framework based on key sociological constructs drawn from the work of Philip Selznick served as a reference point for analysis of the data. Selznick paid particular attention to the adaptation of the organization to internal and external pressures, the process of institutionalization, and the role of the leader in defining and re-defining the mission and role of the organization.

This research was conducted within the naturalistic paradigm, utilizing qualitative methodology; findings were expressed as working hypotheses. In keeping with the Selznick perspective, working hypotheses were organized into five categories: changing mission and role, internal pressures, external pressures, problems encountered, and leadership.

In this study the Selznick perspective was found to be useful in analyzing and interpreting data. Additional in-depth studies are needed

to clarify the role of the leader and the external and internal pressures which result in successful or unsuccessful adaptation in public institutions such as mental hospitals.

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Early in my career it was my good fortune to be a student of Dr. Rae Chittick, Dean, School for Graduate Nurses, McGill University. It can be said that Dr. Chittick left her mark on all her students as she modeled her high standards of academic excellence and encouraged her students to achieve to the best of their abilities.

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Chapter 1

Introduction

The study which is the subject of this report focused on adaptive change and leadership in a large psychiatric hospital. Opened in 1911, the hospital was designed to care for the needs of the mentally ill in the recently created province of Alberta. Over the years the institution has undergone many changes. This process of change, with emphasis on organizational adaptation and the role of leadership in adaptive processes, was the major thrust of the study.

Associations are formed when individuals sharing a common perception of needs organize themselves into a group for the purpose of achieving the goals identified by members. When such associations are more broadly perceived as meeting societal objectives, a formal structure may evolve out of which develops a stable organization. Leaders of organizations need to be aware of and respond to internal pressures within the organization and external pressures in the environment. To survive, organizations must develop an adaptive capacity which meets changing societal demands and expectations.

The mental hospital is an example of an organization developed at a particular point in time to meet societal needs. As society's expectations changed, the mental hospital was required to meet changing expectations. The adaptive processes of one organization, Alberta Hospital Ponoka, together with the role of the leaders in implementing changes, are the focus of this study.

The first chapter provides a general introduction to the study, the statement of the problem, the significance of the study, definitions of the terms used in the study, delimitations and limitations, a brief presentation of the setting at Ponoka, and the rationale for the decisions to use the work of Selznick (1957) as the conceptual basis for the analysis and interpretation of the findings.

Statement of the Problem

The purpose of the study was to investigate adaptive change in a psychiatric hospital, with particular emphasis on the role of the leader in implementing change in the organization. Four main questions guided this research:

1. What were the essential characteristics of selected critical events in the evolution of the hospital?

2. How were the organization's mission and role redefined as a result of important events in its development?

3. How did the organization shift its goals and priorities as a result of internal and external pressures?

4. What were the specific problems encountered as new policies were developed and implemented?

These questions reflect the general perspective of the study and the focus on adaptive social processes within a particular organization. Addressing these four questions led to the development of a fifth:

5. What was the leader's role in facilitating the adaptation of the organization to important events in its development?

This final question directs attention to the cultural aspects of leadership and organizational and administrative processes, rather than to organizational and administrative behavior and leadership styles.

Three critical events were selected for analysis: the elimination of mechanical restraint (1928-1936), the introduction of the tranquilizers (1953-1958), and the deinstitutionalization of patients (1967-1975).

Significance of the Study

The need to study adaptive change and leadership in organizations is related to several factors: Change is a constant in society; the old models of leadership do not work; and constrained resources will force leaders of organizations to become increasingly creative and innovative. In a documentary study of the life history of a mental hospital from its inception to its closure, Stotland and Kobler (1965) suggested that "the character of each mental hospital affects the behavior and symptomatology of its patients, and community factors influence the character of an institution--perhaps especially of a mental hospital" (p. 3). A major focus of the study was the critical events which affected the development of the organization's character and therapeutic milieu for patients and staff. This relationship is explained by Stotland and Kobler:

> There is no question that the treatment and welfare, and progress and behavior, of patients in a hospital—any kind of hospital, though especially a mental hospital--are affected by the therapeutic personnel, by their behavior, beliefs, hopes, and expectations. A relationship exists also between the therapeutic excellence of a hospital and the effectiveness of its ideology and social structure in supporting hopefulness in the staff; for hope is an important therapeutic agent, and patients "catch" hope from the staff. (p. 11)

Stotland and Kobler concluded that the loss of hope among the staff and the failure of leadership contributed to the rash of patient suicides which took place at the hospital prior to its closure. Conflicts in the groups within and outside the institution resulted in the loss of hope among the personnel. In the view of the researchers, leadership plays a critical role in maintaining the ideology of hopefulness and dedication of personnel: The leader "inculcates belief, faith and hope" (p. 16). As the leadership in the hospital deteriorated, there was a concomitant loss of hope and a decline in morale at the hospital.

Organizations are important cornerstones of society, and the mental hospital is an example of an organization which, in the past, has performed an important function for society. Those individuals who were deemed "troublesome" were removed by society to the mental hospital, and in this process the mental hospital achieved a special sense of value. To remain creditable and survive, institutions need to meet the shifting demands of society. As society's views about mental illness and treatment changed, public expectations about the care and treatment of the mentally ill shifted from a custodial orientation to a more humanitarian approach. This study, with its focus on the mental hospital as an organization which has attempted to meet changing societal expectations about its role and function, may contribute to the literature on organizational adaptation.

Viewing organizations as a vital component of the social order, Hall (1977) stated that "organizations are affected (manipulated) by their environment and in turn attempt to affect (manipulate) the environment" (p. 5). Because organizations are in constant interaction with other organizations, clients, customers, and societal conditions, they may seek to expand their influence and either become agents of change or obstruct societal change. While recognizing that leadership in organizations may be constrained by the structure of the organization, power groups, or environmental conditions, nevertheless Hall supported the view that leadership is important in "changing organizational directions, developing new activities, considering mergers or acquisitions, and setting long-run policies and objectives" (p. 255).

In view of the leading role that organizations play in the modern world, Scott (1981) declared that there are theoretical and practical benefits to be gained in increasing our understanding of organizations. He justified the study of organizations by stating that they "provide the setting for a wide variety of basic social processes, such as socialization, communication, ranking, the formation of norms, the exercise of power, and goal setting and attainment" (p. 7). Scott noted that organizations enable society to achieve goals that would be beyond the reach of any one individual. Unfortunately, organizations are also, in Scott's view, the source of some of society's problems. Among the difficulties that may be experienced by individuals in organizations, Scott identified "alienation, overconformity, and stunting of normal personality development" (p. 5).

Results of this study, with its focus on adaptive social processes within an organization, have potential to add to the theoretical body of knowledge on adaptive change and evolution of organizational forms and practices. Through exploring the relationship between institutional change and leadership, this investigation may contribute to the research literature and theory development on leadership and institutional change.

The results of this study may have practical significance for those who spend their working lives in organizations either as leaders or as members of an organization. In particular, the outcomes may enhance understanding of the adaptive social processes within a particular organization and the role leaders play as they attempt to cope with the internal forces and external social pressures on the organization. A measure of the practical significance of this study is the extent to which the outcomes have potential to illuminate the social processes experienced by the people caught up in the change. Particular implications will be described for the role of the leaders within a psychiatric hospital in the process of adaptation.

Definitions

Leader: According to Selznick (1957), the function of the leader is

> to define the ends of group existence, to design an enterprise distinctively adapted to these ends, and to see that the design becomes a living reality. These tasks are not routine; they call for continuous self-appraisal on the part of the leaders; and they may require only a few critical decisions over a long period of time. (p. 37)

Leadership: In Selznick's (1957) view, the essence of leadership is in the area of "critical experience rather than routine practice" (p. 36). Thus, leadership is concerned with the making of critical decisions which have a profound effect on the functioning of the organization.

Organization: An organization is characterized by Selznick (1957) as "a formal system of rules and objectives" (p. 5). The term itself "suggests a certain bareness, a lean, no-nonsense system of consciously co-ordinated activities. It refers to an *expendable tool*, a rational instrument designed to do a job" (p. 5).

Institution: Organizations become institutions, in Selznick's (1957) view, as they are "*infused with value*, that is, prized not as tools alone but as sources of direct personal gratification and vehicles of group integrity. This infusion produces a distinct identity for the organization" (p. 40).

Dynamic adaptation: Selznick (1957) defined dynamic adaptation as "more than simple activity, change, or growth" (p. 34), but, rather, "the reconstruction of a need, the change in posture and strategy, the commitment to new types of satisfaction" (p. 34).

Adaptive change: The concept of adaptive change is, in Selznick's (1957) view, related to "the evolution of organizational forms and practices" (p. 12). As the organization is faced with new, generally unplanned situations, the evolution of organizational forms and practices takes place.

Deinstitutionalization: This term is not related to Selznick's (1957) concept of institutionalization, but to organizations. The implementation of the concept of deinstitutionalization resulted in the discharge of many mental hospital residents into the community. Bachrach (1976) noted that the term deinstitutionalization is confusing for many people and proposed the following definition: "a process involving two elements: (1) the eschewal of traditional institutional settings--primarily state hospitals--for the care of the [chronically] mentally ill, and (2) the concurrent expansion of community-based services for the treatment of these individuals" (p. 1).

Delimitations and Limitations

A number of delimitations and limitations are relevant to this study.

Delimitations. This study was delimited to one particular psychiatric hospital. Examination of the adaptive processes and leadership was restricted to three events between 1928 and 1975.

Limitations. The study reflects the limitation of research that is based in a particular theoretical perspective. An alternative theoretical orientation would likely yield different interpretations.

The availability of interviewees and the interviewees' responses to the questions may pose some limitations on this study. Since some time had elapsed between the events and the interviews, some questions may arise about the accuracy of the interviewees' recollections. Generalizations from this study may not be appropriate to other psychiatric facilities. The critical events selected for study in this organization may not have the same relevance for other psychiatric facilities.

The Ponoka Setting

Situated at Ponoka, the Provincial Hospital for the Insane opened on July 4, 1911, and "was heralded as an example of progress" (Johnson, 1986, p. 2) in the Province of Alberta. The building, designed by A. M. Jeffers, Provincial Architect, was based on the plans of the acute care hospital at Utica, New York (Roberts, 1973, p. 191). In his first annual report, Dr. T. Dawson, Medical Superintendent, recorded in 1912 that "sixteen new cases were admitted from Alberta during that month and on the 24th, 164 were transferred from Brandon, viz. 108 males and 56 females" (Dawson, 1912, p. 1).

The rapidly growing population in Alberta during the 1920s resulted in increasing admissions to the hospital, necessitating a continuous construction program. In a written historical account of the district, Roberts (1973) described this phase of the development of the hospital as "the construction years" (p. 197). In an attempt "to make the institution self-sustaining" and "for the therapeutic value of farm work for patients," a farming operation was a mainstay of the hospital from its beginning (p. 28).

From its early beginnings the hospital was faced with an ever-increasing number of patients and limited financial and human resources. Table 1 (courtesy of Medical Records, Alberta Hospital Ponoka) illustrates the rapid increase in the number of patients from 192 in 1911 to 684 in 1920. Severe overcrowding, the absence of adequate financial resources, and insufficient personnel created a stressful and difficult situation for both patients and staff.

Many of the staff interviewed mentioned the small number of staff available on the wards during this time. Two available documents help to illuminate this situation. In a 1929 report to the provincial government, Hincks and Farrar mentioned that there were 95 staff at the hospital (p. 30). On February 5, 1929, Mr. Hoadley, Minister of Health, was asked by a member of the opposition to provide a complete list of the staff at the hospital. The information provided for the legislature as a result of this question is summarized in Table 2.

The figures in the table provide some insight into the amount of work the patients must have contributed to the overall functioning of

Table 1

Provincial Mental Hospital

Year	Population	Change
1911	192	
1912	223	+31
1913	287	+64
1914	380	+93
1915	445	+65
1916	509	+64
1917	567	+58
1918	517	-50
1919	630	+113
1920	684	+54
Total increase		492

the hospital. With five staff in the kitchen and a patient count of 1,086 (1929), patient help was absolutely essential in feeding such a large group. The same can be said of the laundry (five) and the farm (five). The hospital was divided according to gender, with 56 nursing staff on the female side of the hospital and 33 attendants on the male side. As this small number of staff covered the hospital 24 hours a day, seven days a week, staffing on the units for any given day was minimal. A total of 100 employees resigned or were fired during this period of time (1928 to February 5, 1929). Among the reasons given for resignations were summer relief (17), further training (5), marriage (9), ill health (9), other employment (10), unsatisfactory performance

Table 2

Total Staff at Alberta Hospital Ponoka, 1929

Position	Number of staff		Number of patients
Clinical			
Medical	6		
Nurses	56		
Attendants	33		
Laboratory assistant	1		
Dietitian	1		
Hydrotherapist	1		
Dentist	1		
Occupational therapist	1		
Total:		100	
Support staff (accountant, kitchen, stores, laundry, tailor, etc.)		38	
Farm employees		5	
Total:		143	1051

(ill-treating patient, influence of alcohol, assault) (28), other (moving to coast, moving back to old country) (22) (PAA 70.414/959).

The beginnings of the Ponoka Hospital reflect the problems which developed in other North American institutions of this era. The original hope for therapeutic care and humane treatment was replaced by a custodial orientation as the increasing number of patients resulted in severe overcrowding in the institution and a shortage of human resources available for their care.

Selznick's Theoretical Perspective

Most appropriate for this research is an orientation which recognizes the importance of social processes in organizational adaptation and the importance of the role of the leader in making critical decisions. The writings of Philip Selznick, who described the institution as a special, complex form of organization with distinctive characteristics, meet this need. The utility of this framework is that it views the institution as an adaptive social organism influenced, developed, and changed through the behavior and beliefs of its members and through the pressures of and interactions with the external environment.

Selznick's (1949) work focused on the organization as a collective operating within a larger system of relations in the pursuit of common goals. His analysis falls within a "structural-functional" model of analysis which identifies needs in the social system that must be met if the system is to survive. The focus is on the social structures in the organization that meet the needs of the social system. Wallace and Wolf (1986) identified three elements employed by the functionalists to analyze social systems:

> 1. the general interrelatedness of the system's parts;
> 2. the existence of a "normal" state of affairs, or state of equilibrium, comparable to the normal or healthy state of an organism; and
> 3. the way that all the parts of the system reorganize to bring things back to normal. (p. 11)

Important propositions in functionalism identified by these writers include the interdependence of the organization's systems and the tendency to restoration of equilibrium, and the concept of shared values.

Many writers (Etzioni, 1969; Hall, 1977; Scott, 1981) have commented on the innovative work carried on by Selznick. Their assessment of his contributions to the study of organizations and leadership is recalled in the following brief outline.

Etzioni (1969) referred to Selznick's work as "classic," particularly his study of the TVA as an organization functioning as a change agent (p. 334); Lane (1986) noted that Selznick's organizational leadership theory was deeply concerned with the inculcation and protection of critical values (p. 129); and Yin (1984) stated, "For many years Philip Selznick's TVA and the Grass Roots (1949) has stood as a classic about public organizations" (p. 123). Yin observed that this study had been republished 30 years after its original publication, reflecting its contribution to case study research (p. 123).

Hall (1977) referred to Selznick's classic study of coöptation, The TVA and the Grass Roots, in which "he documents the impact of bringing new societal elements into the governing structure of the T.V.A." (p. 77). Hall credited Selznick with providing the needed distinction between leadership and power. Leadership for Selznick (1957) involved more than group maintenance; it involved the making of "critical," not just routine, decisions.

Scott (1981) noted that Selznick had developed "a unique natural systems model" (p. 90) based upon the structural-functionalist perspective. According to Scott, "this model assumes that the social unit, in our case the organization, has certain needs or requirements, that must be met if it is to persist in its present form" (p. 84). In addition, "if the organization is to survive, information about salient changes in its environment must be communicated to decision makers; the internal communication system performs this function" (p. 84). In addition, he noted, this model emphasizes that the structural elements are themselves mutually interdependent so that variation in one causes modification in the others (p. 85).

Scott (1981) expressed concern about Selznick's cynicism in that he (Selznick) appeared to go out of his way "to inspect the seamy side of organizational life" (p. 94). In Scott's view, Selznick is a "clinical sociologist," and hence his focus is primarily on deviance and abnormality.

In his book Leadership in Administration, Selznick (1957) "explores the nature of critical decisions and institutional leadership" (p. 3). He cautioned that the use of "mechanical metaphors" (p. 3) such as "smooth running machine" may prevent the analyst from perceiving the "really critical experiences of organizational leadership" (p. 3). The term organization for Selznick "suggests a certain bareness, a lean no-nonsense system of consciously co-ordinated activities. It refers to an expendable tool, a rational instrument engineered to do a job" (p. 5). "An 'institution' is more nearly a natural product of social needs and pressures--a responsive adaptive organism" (p. 5). His analysis paid particular attention to the historical evolution of the organization and the need to place the "interpretation of organizational behavior in historical perspective" (p. 101). In support of this view, Selznick (1949) stated:

> All formal organizations are moulded by forces tangential to their rationally ordered structures and stated goals. Every formal organization attempts to mobilize human and technical resources as means for the achievement of its ends. . . . the organization may be viewed as an adaptive social structure facing problems which arise simply because it exists as an

> organization in an institutional environment independent of the special (economic, military, political) goals which called it into being. (p. 25)

For Selznick (1957), institutional studies take into account both internal and external forces and "emphasize the adaptive change and evolution of organizational forms and practices" (p. 12). For him, "the story is told of new patterns emerging and old ones declining, not as a result of conscious design but as natural and largely unplanned adaptations to our situations" (p. 12). Legal and formal changes were viewed as recording what has been already completed informally.

The external environment. Among the essential features of the external environment, according to Selznick (1949, 1957), are the coöptation of interest groups, the social environment, community needs, and potential clients. The social environment may result in external pressures forcing the organization into coöptation of interest groups. Selznick (1949) defined *coöptation* as "the process of absorbing new elements into the leadership or policy determining structure of an organization as a means of averting threats to its stability or existence" (p. 13). The process may be formal or informal, but the final result is a change that is "consequential for the character and role of the organization or governing body" (p. 15).

Another idea promoted by Selznick (1949) for use by the organizational analyst was the notion of unanticipated consequences as a "key analytical tool." This focus on the meaning of events leads to the notion of "sociologically identifiable forces at work" (p. 254) and the need to "uncover systematically the sources of unanticipated consequences in purposive action" (p. 254). Thus, in the process of developing a "distinctive clientele," the enterprise, in Selznick's

(1957) view, gains stability through having a secure source of support, but, "at the same time, it loses flexibility" (p. 7), and the process of institutionalization has set in.

The internal environment. Selznick (1957) reminded us that an organization is a group of living human beings who have their own needs and who create human relations that are a great "reservoir of energy" (p. 8). He commented that "one objective of sound management practice is to direct and control these internal social pressures" (p. 8). He believed that there was a need to develop a balance between the fragmentary interests of groups and the aims of the whole institution. Selznick defined institutionalization as follows: "Institutionalization happens to an organization over time, reflecting the organization's own distinctive history, the people who have been in it, the groups it embodies, and the vested interests they have created, and the way it has adapted to its environment" (p. 16). Further, Selznick stated, "to institutionalize is to infuse with values beyond the technical requirements of the task at hand" (p. 17). As the organization becomes increasingly institutionalized through the embodiment of values, he suggested that it acquires a "self" (p. 21) and becomes increasingly concerned with self-maintenance and a need to preserve the uniqueness of the group. Selznick paid particular attention to the history of the organization and how it has been influenced by its social environment. Further, he commented that it is important to pay attention to existing centers of power in the community, to the strata of society from which the leadership comes, and to "how it justifies itself ideologically" (p. 61).

Selznick (1957) compared the development of organizational character to the idea of "character" as used by the personality analysts. This phase of institutional analysis emphasizes "the embodiment of values in an organizational structure through the elaboration of commitments--ways of acting and responding that can be changed, if at all, only at the risk of severe internal crisis" (p. 40). Selznick compared homogeneity of outlook, or the unity of response in an organization, to the need of an individual for a unified pattern of response to his environment. This integration of response "will define in advance the general attitudes of personnel to specific problems as they arise" (p. 181).

Leadership functions. Selznick (1957) argued that policy and administration are interdependent and that creative men are needed "who know how to transform a neutral body of men into a committed polity. These men are called leaders; their profession is politics" (p. 62).

Selznick (1957) distinguished the leader from the manager. The leader of the institution is concerned with "critical" decisions, as opposed to routine. In his view, the institutional leader "is primarily an expert in the promotion and protection of values" (p. 28).

The function of the leader, according to Selznick (1957), is to define the ends of group existence, to design an enterprise distinctively adapted to these ends, and to see that the design becomes a living reality" (p. 37). For Selznick, the quality of institutional leadership is found in the area where policy formation and organizational building meet. There is a need for the leader to develop a *Weltanschauung*, defined as "a general view of the organization's position and role among its contemporaries" (1949, p. 47).

Some of the key tasks leaders need to perform, according to Selznick (1957), are:

1. The definition of institutional mission and role.
2. The institutional embodiment of purpose.
3. The defense of institutional integrity.
4. The ordering of internal conflicts. (p. 62)

Each organization, according to Selznick (1957), develops special capabilities and limitations as the institutionalization process proceeds (p. 49). Other critical tasks of leadership were synthesized by Selznick (1957) to include the recruitment of personnel, the training of personnel, the representation of internal group interests, and cooperation with other organizations (pp. 58-59). Finally, Selznick (1957) linked leadership, character, and critical decision making as aspects of the institutionalization of organizational life.

Utilizing the methodology and writings of Selznick, key "turning points" in the development of the hospital were selected for analysis. To be selected for analysis, these major policy developments must have resulted in some redefinition of the institution's mission and role, external pressures were influential in the implementation of the policy, internal pressures and value changes were a factor, and leadership was needed for the implementation of the policy. The three critical events meeting the above criteria and selected for analysis in this dissertation were the elimination of mechanical restraints (1928-1936), the introduction of the tranquilizers (1953-1957), and deinstitutionalization (1967-1975).

Organization of the Thesis

This thesis has been organized into nine chapters. This chapter provided an introduction to the study, the statement of the problem, the significance of the study, definitions of terms, delimitations and limitations, an introduction to the Ponoka setting, and the rationale to use the work of Selznick. Chapter 2 presents a review of the literature on change in organizations generally and change in mental hospitals specifically. Chapter 3 reviews the related literature on leadership and organizational culture. The research design and methodology are developed in Chapter 4. The evolution of procedures and practices in mental hospitals provides a context for reports of the Ponoka experience. The first of the three critical events, the elimination of mechanical restraints (1928-36), is presented in Chapter 5. The report of the introduction of the tranquilizers (1953-57) is presented in Chapter 6. The third and final critical event, deinstitutionalization (1967-75), is examined in Chapter 7. Chapter 8 presents a discussion and interpretation of the findings. The final chapter (Chapter 9) addresses the conclusions of the study and reflects on the process through which it was carried out.

Chapter 2

Change in Organizations

The purpose of this chapter is to explore some of the theoretical perspectives on change in organizations. In the first section several definitions of organizational change are presented. This is followed by an exploration and review of some specific conceptualizations in the field of organizational change and the change facilitation process. The chapter concludes with a review of the historical development of mental hospitals.

The past four decades have been a time of rapid and dramatic change in our society. The truism "We live in a world of constant change" has become a well-worn cliche. Individuals and organizations have had to adjust to major cultural, economic, societal, and technological developments. For some there may be a magical sound to the word change. Perhaps the word itself taps into a feeling of hope that the conditions under which people live and work will somehow be better than they have been. For others the opposite may be true. Change portends further complications in their lives with increasing confusion and insecurity. An increasingly technological society may seem to have eroded the quality of lives and undermined traditional values of family, home, religion, and society.

Definitions of Change

Definitions of organizational change reflect the theoretical perspective of individual theorists. Terms such as change (Hodge & Anthony, 1984; Lewin, 1951), adaptive change (Selznick, 1957), organizational change (Bennis, 1966; Veninga, 1982), organizational innovation (Argyris, 1965; Hasenfeld, 1983), planned change (Havelock, 1973), organizational renewal (Lippitt, 1969), and organizational development (Bennis, 1969; French, Bell, & Zawacki, 1978; Gibson, Ivancevich, & Donnelly, 1979) are all used to refer to the process of change in organizations.

The process of change in which the character and role of an organization are altered was described by Selznick (1957) as "adaptive change" (p. 12). New situations, "largely unplanned" (p. 12), result in the development of new organizational forms and practices. These adaptations significantly change "the role and character of the organization" (p. 12).

Bennis (1964) noted that not all change in organizations is "planned change." He developed a paradigm in which eight types of change were identified. These included indoctrination, coercive, technocratic, interactional, socialization, emulative, natural, and planned change (pp. 154-156). Planned change for Bennis (1964) "entails mutual goal setting by one or both parties, an equal power ratio, and deliberateness, eventually, at least, on the part of both sides" (p. 154). Bennis (1969) defined organizational development as "a response to change, a complex educational strategy intended to change the beliefs, attitudes, values, and structure of organizations so that they can better adapt to new technologies, markets, and challenges, and the dizzying rate of change itself" (p. 2).

Lippitt (1969) recognized the confusion created in the field of organizational development by the lack of agreement among writers on the definitional issues of organizational development, organizational renewal, planned change, and organizational improvement. At the beginning of his book, Lippitt provided a glossary of the terms he would be utilizing. Organizational renewal was defined as

> the process of initiating, creating, and confronting needed changes so as to make it possible for organizations to become or remain viable, to adapt to new conditions, to solve problems, to learn from experiences, and to move toward greater organizational maturity. (p. 1)

Organization development was "the strengthening of those human processes in organizations which improve the functioning of the organic system so as to achieve its objectives" (p. 1). Lippitt went on to define change as "any planned or unplanned alteration of the status quo in an organization or process" (p. 2), and planned change as "an intended, designed, or purposive attempt by an individual, group, organization, or larger social system to influence directly the status quo of itself, another organism, or a situation" (p. 2).

Others writers, such as Chin and Benne (cited in French, Ball, & Zawacki, 1978), defined planned change as an attempt to bring about change which is "conscious, deliberate, and intended, at least on the part of one or more agents related to the change attempt" (p. 32). They stressed the necessity for the change agent to have knowledge of individual and social human behavior.

In 1978 French, Bell, and Zawacki noted that the area of planned organizational change which they termed organizational development (OD) was less than 20 years old. They warned readers that there was "a pronounced lack of clarity and consensus concerning both the whole of OD and the component parts of OD--theorists and practitioners differ widely among themselves on methods, processes, goals and even definitions of organization development" (p. 1).

Emphasizing that organizational development is a kind of change process designed to bring about a particular end result, French, Ball, and Zawacki (1978) presented the following definition:

> Organization development is a process of planned, system change that attempts to make organizations (viewed as social-technical systems) better able to attain their short- and long-term objectives. This is achieved by teaching the organization members to manage their organization processes and culture more effectively. Facts, concepts, and theory from the behavioral sciences are utilized to fashion both the process and the content of interventions. A basic belief of OD theorists and practitioners is that for effective, lasting change to take place, the system members must be able to grow in the competence to master their own fates. (p. 6)

Reflecting on the difficulty of classifying the literature on organization change, Gibson, Ivancevich, and Donnelly (1979) noted that the current trend is to use the term organizational development when referring to the process of "preparing for and managing change" (p. 458). These authors examined several definitions of organizational development and found them to be incomplete and therefore unacceptable. They proposed the following more comprehensive definition:

> The term "organization development" . . . implies a normative, re-education strategy intended to affect systems of beliefs, values, and attitudes within the organization so that it can adapt better to the accelerated rate of change in technology, in our industrial environment and society in general. It also includes formal organizational restructuring which is frequently initiated, facilitated and reinforced by the normative and behavioral changes. (p. 459)

The contemporary field of organizational development is, according to these authors, described by eight characteristics: (a) planned, (b) problem oriented, (c) reflects a system approach, (d) an integral part of the management process, (e) not a "fix-it" strategy, (f) focuses on improvement, (g) action driven, and (h) based upon sound organizational practice (pp. 459-460).

Another influential point of view about change in organizations has been presented by LaPorte, Adams, and Andrews (1981), who used the term change to refer to "any alteration of the status quo" (p. 19:2). There is a relationship between change and the need of the organizational leader to respond to this stimulus through organizational adaptation. Accordingly, change is viewed as any stimulus imposed on the organization requiring the organization to respond (to act). Change, external or internal, is something which happens to an organization. Adaptation is initiated by the organizational leader in response to or in anticipation of change and is always internal.

Definitions of change in organizations reflect the different emphases and theoretical perspectives of the various writers. Planned change has been generally defined as a conscious, deliberate effort to bring about an alteration of the status quo. Adaptive change has been generally viewed as an adjustment or modification in the status quo of an organization affecting the personnel, role, and structure of the organization. In this study the theoretical orientation which comprised the cornerstone of Selznick's research and views organizations as adapting to both external and internal pressures served as the organizing principle.

Conceptual Models of Change

The origin of the systematic study of change is generally credited to the pioneering work of Kurt Lewin (1948, 1951). His research on small groups and larger organizations is considered classic in this field. In 1945 the Research Center for Group Dynamics at the Massachusetts Institute of Technology was founded under his direction, and the roots of the study of organizational change can be found in this school of social research. Lewin was convinced that theories must be tested in action, and his research concentrated on the specific practical problems of modern society.

A fundamental construct in Lewin's (1951) theory is the idea of "field." For Lewin, "field theory emphasizes the importance of the fact that any event is a result of a multitude of factors" (p. 45), and his definition of field theory emphasizes the notion of causal relations. "_Field theory is probably best characterized as a method_: namely, a method _of analyzing causal relations and of building scientific constructs_" (p. 45). In describing basic field theory, he emphasized:

> (a) behavior has to be derived from a totality of coexisting facts; and (b) these coexisting facts have the character of a "dynamic" field in so far as the state of any part of this field depends on every other part of the field. (p. 25)

Lewin emphasized the need to view the life space of a person, which he defined as the person and her or his environment, as a holistic, unified field. A constellation of psychological forces was seen by Lewin (1951) as affecting one's ability to change. At a particular point in a life space, "the construct-_force_ characterizes the direction and strength of the tendency to change" (p. 256). Lewin proposed the idea of positive and negative valences in meeting needs:

> An increase in the intensity of need (for instance, the need for recreation) leads to an increase of the positive valence of certain activities (such as going to the movies or reading a book) and to an increase in the negative valence of certain other activities (such as doing hard work). Any statement regarding change of needs can be expressed by a statement about certain positive and negative valences. (p. 273)

Lewin's (1951) early work on the role of the peer group in individual change and decision making has had a pervasive influence on research in this area. Lewin viewed the existing situation in an organization as being maintained in a field of driving and restraining forces. A driving force is one that helps move events in a given direction; a restraining force is experienced in terms of physical or social obstacles to the events moving in a particular direction. Lewin's theory of change involved three basic stages: unfreezing, moving, and refreezing. The first step, unfreezing, recognizes the need for change and for reducing those forces within the organization that serve to maintain the present form or level of behavior. In the second phase, moving, the organization and its members try out the innovation; new behaviors, values, and attitudes are developed. In the third stage, refreezing, members integrate the change into their value systems, and the organization stabilizes.

Several researchers have modified and expanded Lewin's (1951) theories about planned change. Lippitt (1969) emphasized the interpersonal aspects of the change process and problem solving in describing seven phases of the change process: diagnosis of the problem, assessment of the motivation and capacity for change, assessment of the change agent's motivation and resources, selecting progressive change objectives, choosing the appropriate role of the change agent, maintenance of the change once it has been started, and termination of the helping relationship. Havelock (1973) identified six phases in the change process: building a relationship, diagnosing the problem, acquiring the relevant resources, choosing the solution, gaining acceptance, and stabilizing and self-renewal (pp. 13-14).

Analysis of the implementation of educational change carried out by Chin and Benne (cited in French, Ball, & Zawacki, 1978) led to the identification of three types of strategies for implementing change. These strategies are not mutually exclusive, frequently overlap, and each has strengths and limitations. The decision to utilize a specific strategy to implement change is dependent on the particular environment. These strategies are empirical-rational, normative-re-educative, and power-coercive (p. 95). The empirical-rational strategy is based on the assumption that everyone is guided by reason (p. 95) and will follow their rational self-interest once it is revealed to them. With trust in the scientific method, ignorance will be replaced with knowledge and people will be freed from their superstitions. This model of change involves the scientific study of an organization to determine the need for change, the development of strategies to determine how the change should be implemented, and evaluation to determine whether or not the change was beneficial. The normative-re-educative strategy emphasizes that individuals must take part in their own re-education if they are to be changed. This model includes direct interventions by change agents and focuses on improving the problem-solving abilities of an organization. Intervention strategies may include personal counselling, laboratory groups, training groups, and psychotherapy. Power-coercive approaches use political power, economic boycotts, moral power, or manipulation of power elites to achieve objectives. Power-coercive change strategies may be distinguished from empirical-rational and normative-re-educative strategies in that those who use power-coercive strategies rely on economic and political sanctions to achieve their goals.

Recognizing that the change process may be far more complex than his model appears to suggest, Steers (1977, p. 168) promoted the use of a flow diagram to highlight the important steps of the process. Changes in the environment, structure, technology, or membership may result in performance gaps in an organization. When this occurs, management must create a climate that promotes change. Diagnosis of the problem and the development of possible change strategies results in the selection of an appropriate change strategy and the implementation of change. Management then evaluates the effectiveness of the change strategy and its success in closing the performance gap. This process then begins anew.

Gibson, Ivancevich, and Donnelly (1979) emphasized that organizational-development programs should be designed systematically. They proposed an eight-step model which, if followed sequentially, would increase a manager's success in introducing change in an organization. In this model the manager recognizes that, in the modern world, the dynamic forces of change are perpetually acting upon the organization. The manager is responsible for assessing these change forces, diagnosing the problem, and choosing an appropriate technique for implementing the change. It is important that the manager monitor the change process and the results through a feedback loop. These writers maintained that managers who wish to implement organizational development programs must commit themselves to making fundamental changes in organizational behavior through provision of rewards and reinforcement for newly learned behaviors.

In implementing change through the process of organizational development, LaPorte, Adams, and Andrews (1981) proposed the use of an action research model. The cyclical nature of this model provides a means of systematically gathering data for planning, implementing, and evaluating action. The leader first becomes aware that change is necessary and makes a preliminary diagnosis. This initial step is followed by gathering information, formulating an action plan, and implementing and evaluating the effectiveness of the intervention. Leaders, when utilizing this model, must be aware that meaningful change takes time and is an ongoing, long-term process.

Rosenblum and Louis (1981) identified two major approaches to the study of organizational change. The first is based on the assumption that change is a manageable process and includes sound program planning, effective choice of strategies, and appropriate support. The second approach views change from a natural-systems perspective and assumes that the basic characteristics of the organizational system are the determinants of success or failure of the change process. Rosenblum and Louis's study of 10 rural experimental schools in the United States found that program design rather than implementation had an important impact on innovation outcomes. The analysis of their findings suggested that none of the systems elements--environment, structure, culture, or input--is singularly more powerful than the others. Rather, each system element makes unique and independent contributions to the explanation of change. Findings from this study, applicable to large-scale innovative efforts, indicated that knowledge of the system, emphasis on the planning process, effective program design, careful participation, strong administrative leadership, and increased collaboration among teachers were factors which affected the successful implementation of change.

Veninga (1982) believed that the most critical challenge facing an effective health-care administrator may be the ability to manage organizational change. He suggests that change be viewed as an ally rather than an enemy, for, if change is initiated "thoughtfully and systematically, it can help us create a more effective and efficient health delivery system" (p. 251). Veninga supported his argument for this position by identifying some of the major issues in health care: The health administrator is faced with "consumers" who not only demand high-quality services but also take increasing responsibility for their own health; consumers are alarmed at the increasing costs of health care and are demanding cost effectiveness and accountability of expenditures. Veninga commented that as the role and purpose of public-health institutions and hospitals are becoming increasingly blurred, there is increased tension and suspicion about each other's motives. Veninga pointed out that "new regulations, changing patterns of financial support, emerging community health problems, and changing opportunities to resolve those problems often create a crisis atmosphere in which systematic planned change may be difficult to achieve" (p. 288). In his view, "the uncertainty and anxiety generated by a crisis makes the membership of an organization eager to adopt new structures that promise to relieve the anxiety" (p. 288).

In an analysis of forces influencing educational change, Miklos (1981) observed that educational change can be discussed in terms of broadly defined organizational change. Miklos utilized earlier work by Cummings and Dunham (1980), adapted from Leavitt (1965), in order to develop his model. According to Miklos, changes in organizations will impact five major areas: the environment, the programs or tasks, the individuals or groups, the structure, and the technology. Miklos stressed that administrators must address two main questions:

1. What changes or innovations are necessary or desirable?
2. What will the consequences be of specific changes? (p. 5)

Situational factors will determine what tasks or techniques are appropriate and who should carry them out. Miklos stressed the need for administrators to have a broad range of technical, human relations, and conceptual skills to implement change successfully.

The central interest of Fullan (1982) in the educational change process was change demonstrated in actual practice--not the development of new policies or programs. He recognized the conflict and ambivalence experienced by those undergoing change and the "sense of mastery, accomplishment and professional growth" (p. 26) that can result if change is successfully implemented. Fullan categorized three broad phases of change recognized by most researchers:

> Phase I: variously labeled initiation, mobilization, or adoption--consists of the process which leads up to and concludes a decision to adopt or proceed with a change.
>
> Phase II: implementation of initial use (usually the first one or two years of use)--involves the first experiences of attempting to put an idea or program into practice.
>
> Phase III: continuation, incorporation, routinization, or institutionalization--refers to whether the change gets built in as an ongoing part of the system or disappears by way of a decision to discard or through attrition. (p. 39)

Although Fullan's research was focused on educational changes, his chart of 10 factors affecting adoption could be applied to the adoption of change in any human service organization. These factors include existence and quality of innovations, access to information, advocacy from central administrators, teacher pressure/support, consultants and change agents, community pressure/support/apathy/ opposition, availability of federal or other funds, new central legislation or policy, problem-solving incentives for adoption, and bureaucratic incentives for adoption (p. 42).

Hodge and Anthony (1984) focused on change which has a significant impact on the organization and explored two aspects of this phenomenon: first, change generated from outside the organization, which they call exogenous change; second, change generated within the organization, endogenous change. In their view, exogenous change will frequently result in endogenous change. The dilemma facing organizations with respect to change was raised by Hodge and Anthony. To remain competitive, organizations must change, yet organizations often resist change because they desire "stability and predictability" (p. 377). The answer to this dilemma, according to Hodge and Anthony, is for managers to assume "that the organizational change process can be managed to some extent" (p. 377). Planned change is possible and will serve to reduce the instability and uncertainty that may be experienced with new initiatives in the organization. Hodge and Anthony developed a 12-step model for analyzing and implementing change. This model recognizes the stress that can occur in organizations and people as a result of changes, because of either internal or external problems (Step 1). In Step 2 this stress becomes an impetus for people to recognize that a problem exists and to decide to do something about it. The stress level will vary depending on people's perceptions of the change (Step 3). Therefore, it is important that management carefully plan and analyze the necessary changes (Step 4). In Step 5 management specifies the results (the goals) that it would like to achieve as a result of the change. Next, activities and programs are planned and employees are fully informed and participate in the planning and decision-making process (Step 6). This participation of employees will result in the unfreezing of behavior (Step 7). Hodge and Anthony noted the need to introduce change incrementally on an experimental basis (Step 8) and to evaluate the change in a systematic, objective fashion (Step 9). The next step in this model recognizes the need to "readjust the planned change" (p. 382) following evaluation (Step 10). Evaluation is followed by implementing the change throughout the organization (Step 11), and, finally, if the process has been implemented successfully, "the members of the organization affected by the change should become so familiar with it that a refreezing of behavior takes place" (p. 383) (Step 12). These writers recognized that the change process is not as neat as depicted in the step model; they nevertheless saw this model as giving managers "some framework by which to analyze change, and it should help managers identify the critical variables in dealing with change" (p. 383).

LaPorte, Adams, and Andrews (1981) believed that the greater the degree of anticipation of change by the leader, "the greater the probability the change will be favourable for the leader" (p. 19:3). Change may be external, imposed by senior leaders at higher levels, or internal, a result of changing needs or demands by subordinates. The source of change and the degree of anticipation of change by the leader are the two key variables in the outcome of change.

Focusing on examples of business and industrial organizations within a free-market economy and giving examples of successful adaptation (Gerber food line) and unsuccessful adaptation (the Chrysler Corporation during the 1970s), LaPorte, Adams, and Andrews (1981) presented a model of an adaptive-coping cycle. This cycle, which they viewed as an organizational problem-solving process, consists of seven stages: sensing, communicating information, decision making, communicating instructions, stabilizing, copying actions, and feedback (pp. 19:6-19:8). According to this view, the success or failure of an organization is related to its ability to adapt to a changing environment. A degree of resistance on the part of individuals or groups is probable and is based on a general fear of the unknown. Individuals may view change and the resulting adaptation as threatening to a comfortable routine. They may fear loss of status or power or the inability to acquire and develop new skills and behavior. Group resistance may be related to a fear of economic loss, a fear of a loss of belonging, or a threat to established group norms. In the view of these writers, the leader can facilitate and overcome resistance to change through demonstrating a genuine need for adaptation, providing additional training and skill development, and allowing subordinates to participate in the process.

Institutionalization

Addressing the issue of the persistence of planned change within organizations, Goodman and Dean (1982) revealed that there are few, if any, well-developed models to explain or predict degrees of institutionalization. An institutionalized act is defined as "a behavior that is performed by two or more individuals, persists over time, and exists as a social fact" (p. 229). These authors supported the notion that organizational innovations and change represent one strategy for improving productivity and working life, and emphasized the need to understand long-run organizational changes. In the Goodman and

Dean study, data were collected and analyzed from nine organizations that had recently undergone organizational change. Focus in these case studies was on degrees or levels of institutionalization rather than on success or failure of organization change. Through an examination of the number of people in the social system performing the act and the degree to which the act existed as a social fact, Goodman and Dean provided insights into degrees of institutionalization. The general framework examining the degree of institutionalization consisted of a set of five processes: socialization, commitment, reward allocation, diffusion, and sensing and recalibration (pp. 235-236). The framework utilized by Goodman and Dean reflects the assumptions that, first, "processes have a direct effect on the facets of institutionalization," and second, "the structure of the change and the characteristics of the organization have indirect effects on the criteria through the processes" (p. 236). Data from this research revealed that institutionalization is not an all-or-nothing phenomenon. Degrees of institutionalization can probably be found in any social context. High levels of institutionalization are associated with training new members, opportunities for commitment, types of rewards, and behavior-reward contingencies. Goodman and Dean cautioned that their sample may have been unique and concluded that difficulties in maintaining change in organizations "will remain a fairly persistent problem" (p. 268). Although change had been successfully introduced in these nine organizations and some benefits had appeared, over time "the majority of the programs had become deinstitutionalized" (p. 268).

Beginning with definitions of organizational change, this section has explored developments in this area by various authors (Chin & Benne, cited in French, Ball, & Zawacki, 1978; Havelock, 1973; Lippitt, 1969). The theoretical orientation of the writers (Fullan, 1982; Laporte, Adams, & Andrews, 1981; Lewin, 1948, 1951; Miklos, 1981; Rosenblum & Louis, 1981) is reflected in the conceptual models of change. The models reflect the complexity and importance of developing an increased understanding of the change process in organizations. The next section of this chapter traces the evolution of mental hospitals as organizations as they attempt to cope with different societal expectations.

The Evolution of Mental Hospitals

Throughout history, certain individuals in all societies have been labeled "insane," "mad," or "mentally ill." Beliefs about the cause of mental illness historically have been rooted in ignorance, superstition, and fear; and treatment of the mentally ill reflected these beliefs. Early treatments were based on the concepts of demonology and exorcism. The need to "drive out the devil" by punishing the unfortunate sufferer was thought to justify the development and implementation of many cruel and unusual "treatments." If scourging proved ineffective, then flogging, starvation, purgatives, and confinement in chains were all viewed as legitimate modes of treatment, with burning at the stake reserved as a last resort. Rooted in a background of misconceptions, and based on the particular social-cultural concepts of the day as to the etiology of mental illness, treatment of the mentally ill may be characterized as a rather horrific example of man's inhumanity to man.

According to Hobbs (1969), the mental-health field has experienced three revolutions. Phillipe Pinel in France, William Tuke in England, and Benjamin Rush and Dorothy Lynde Dix in America are most frequently cited as contributing to the first revolution. These public-spirited people promoted the idea that the mentally ill are human beings who respond positively when treated with kindness and dignity. They campaigned actively against the inhumane conditions to which the mentally ill were subjected in their respective countries.

The second mental-health revolution, according to Hobbs (1969), was influenced by Sigmund Freud. Throughout the western world, his ideas, spread by his disciples, have had a profound effect on culture and on beliefs about human beings. Stanton and Schwartz (1954) recognized the influence that the psychoanalytic literature has had on mental hospitals, because it emphasized the "importance of the relations of the patients with the people about them and attempts to organize knowledge of what a patient requires upon the basis of emotional attitudes and meanings to the patient of various aspects of hospital procedure" (p. 423). Their criticisms of the influence of psychoanalytic thought on the functioning of mental hospitals are related to the view that patients are considered to be passive nonparticipants in the treatment process.

The penetration of public health concepts into the field of mental health resulted in the third revolution, the community mental-health movement. Rossi (1969) disagreed with those who dichotomize this development into pre-World War II (early) and post-World War II (later). For Rossi, "community mental health philosophy and activities had been developing gradually since at least the beginning of this century and possibly earlier" (p. 9).

The changes taking place in mental health were commented on by Hobbs (1969):

> The therapeutic community, the open hospital, the increased interest in children, the growth of social psychiatry, the broadened base of professional responsibility for mental health programs, the search for new sources of manpower, the quickened concern for the mentally retarded, the proposed comprehensive community mental health centers, these developments are evidence of a deep-running change, indicative of this: The concepts of public health have finally penetrated the field of mental health. (p. 30)

The development of mental hospitals in Europe. In the sixteenth century, monasteries, the original repositories for the "possessed" or "insane," began to be replaced by "special institutions" (Coleman, Butcher, & Carson, 1980, p. 39). Unfortunately, treatment in these early hospitals or "asylums," as they came to be called, continued in accord with traditional misconceptions. An example of these inhumane conditions is reflected in the monastery of St. Mary of Bethlehem which, in 1547, King Henry VIII converted into a hospital for the insane. "Bedlam," as it came to be known, exhibited the more violent patients "for one penny a look," and "the more harmless inmates were forced to seek charity on the streets of London" (p. 39).

Based on the conviction that the community needed to be protected from the inmates and the inmates from the possible damaging effects of family and friends, these modified penal institutions were gradually established in many countries. Coleman et al. (1980) made the point that the inmates were treated as "animals and criminals," were regarded as subhuman beings or agents of Satan, and as late as 1830 "had their heads shaved, were dressed in strait jackets, put on a low diet, compelled to swallow some active purgative, and placed in a dark cell" (p. 41).

In the majority of these early institutions, inhumane conditions were the accepted norm. Several valiant attempts, however, were made by pioneering caregivers toward improving conditions for the mentally ill. Among those credited with the initiation of humanitarian reform in the asylums are William Tuke of England, a Quaker, who in 1796 opened the York Retreat where mental patients were treated with kindness and rest in a religious atmosphere. In 1792, in France, Pinel (cited in Coleman et al., 1980) freed the mentally ill from chains and promoted the idea of an environment which was organized and structured so that patients could participate in activities. In America the first systematic book on mental illness, Medical Inquiries and Observations of the Mind, was written by Benjamin Rush and published in 1812. Although Rush is given credit for advocating more humane treatment of the mentally ill, he was not entirely free from the traditional beliefs of the time. He advocated, for example, the use of the "circulating swing" and a device which he invented called the "tranquilizing chair." According to Rush (1812/1962):

> the tranquilizer has several advantages over the strait waistcoat or med shirt. It opposes the impetus of the blood toward the brain, it lessens muscular action every where, it reduces the force and frequency of the pulse, it favours the application of cold water and ice to the head and warm water to the feet, both of which I shall say presently are excellent remedies in this disease. (p. 182)

In England, Sir W. C. Ellis (1838), resident Medical Superintendent of the Pauper Lunatic Asylum, Hanwell, Middlesex, published his A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity, which marked the culmination of nearly 20 years of work with the mentally ill and "observation of upwards of 2,700 cases" (p. vii).

According to Ellis (1838):

> Insanity may be traced to three classes of causes,--viz. direct physical injuries of the brain, over-excitement from moral causes, and diseased action in it from sympathy with some other part of the body. It becomes a matter of very

> serious inquiry to ascertain how far the circumstances which produce it are either directly or remotely under our control. (p. 324)

This text explores the nature and causes of insanity in great detail, and his belief about the "moral causes" are reflected as follows:

> But the cases of insanity arising from direct physical injuries are comparatively few, and but little can be done to avoid their occurrence: those which have their origin from moral causes are by far more numerous, and fortunately much more capable of being avoided: they are generally the result of our having an undue estimate of the things of this life. (p. 325)

Ellis (1838) believed that

> medical remedies, on which much reliance is to be placed, are but few, and that they are principally of use in the early stages of the disease. The moral treatment is by far the most difficult part of the subject. In this the most essential ingredient is constant, never-tiring, watchful kindness. (p. 6)

He supported his views with in-depth discussion of the many patients he had treated over the years. His views on the use of restraint, particularly in the treatment of mania, are of particular interest:

> In all cases where the patient begins to be ungovernable, the kindest and least afflicting mode of proceeding, even to the patient himself, is to procure such an overwhelming power to restrain him as to make him feel it useless to resist. Very few indeed will contend with three or four determined persons; but if only one or two be present, the most violent opposition is made. The most simple and least objectionable mode of confinement, is that of a pair of wide canvas sleeves, connected by a broad canvass shoulder-strap, so as to rest easily on the shoulders. They ought to come up well on the shoulders, and to extend about an inch beyond the ends of the fingers: the part covering the hand should be made of tolerably stiff leather, to prevent the hand grasping any thing. They keep the arms hanging easily, and in a natural position, by the sides of the body. They are fastened at the back by two straps, one going from one sleeve a little above the elbow, across the loins to a similar position in the other sleeve; a second lower down, and by three similar straps in the front; the latter being secured by buckles, which, in large establishments, where there are many patients to be attended to by one keeper, ought to be locked. (pp. 163-164)

Although Ellis (1838) cautioned that "it is unwise and cruel for the whole party to fly at the poor patient," he advocated "another very convenient and easily made form of confinement," the "arm-chair" (p. 165). Ellis described this device:

> Each of the arms of the chair forms a padded box, which incloses the arm of the patient, from a little below the elbow to the wrist. The box ought to be sufficiently large to contain the arm quite loosely, and without any pressure, and the hand will remain at liberty. A board, which forms a very convenient rest, is attached by hinges to the inner side of one of the arms of the chair, and is fastened to the other arm. When the confinement of the arms is unnecessary the box may be opened, and the patient may still remain fastened in the chair, by means of a loose strap passing in front of the body, through two holes at the back of the chair, and there buckled. The chair may be fitted with a foot-board, a little elevated above the floor, and perforated with holes. Under this board a vessel constantly filled with hot water, ought to be kept, in cold weather. (pp. 165-166)

Another early advocate of the "nonrestraint system" was Robert Gardiner Hill (1857), Resident Medical Superintendent of the Lincoln Lunatic Asylum, Lincolnshire, England. In his text Non-Restraint System of Treatment in Lunacy, he noted that before the work of Pinel, "moral and humane treatment was never attempted" (p. 145). Criminals and lunatics were grouped together and, in order to survive, were frequently forced to live promiscuously. In addition,

> instruments of restraint of the most cruel description were constantly resorted to; instruments which deprived the patient of all power and command over himself, and reduced him at once to the most abject state of helplessness, misery, filth, and wretchedness. Food was thrust down the throat, and the mouth forced open by one of those instruments of cruelty, the use of which was occasionally attended with fatal results. (pp. 145-146).

In addition to crediting Pinel for his efforts to humanize treatment of the mentally ill, Hill (1857) referred to the work of Daniel Tuke in England and applauded the work of the "Quakers," who "took the lead in this country in their admirable Institution the Retreat" (p. 146), and remarked that "once it was proved that moral means were efficacious, improvements rapidly advanced" (p. 146). He stated:

> Everywhere the light seemed to flash upon mankind, that these unfortunate beings were still of the same race and order with themselves, and had some claim to an attempt at at least a kind and feeling treatment. The attempt once made, its efficacy was undeniable; and now there does not exist an Institution where kindness is not held forth as the principal means resorted to for the recovery of the insane. The very name of "Mad-house" is almost forgotten. In place thereof an "Asylum" is offered for these poor creatures:--a place of refuge, of shelter from injury, of comfortable retreat, until the storm be overpast--a place where every want is attended to, every reasonable wish gratified. (p. 146)

He went on to urge the abandonment of the word "Mad-house" (p. 146), to be replaced by "Asylum" (p. 146), which he defined as "a place of refuge, of shelter from injury, of comfortable retreat, until the storm be overpast:--a place where every want is attended to, every reasonable wish gratified" (p. 146). Hill saw himself as completing the work "which Pinel began" (p. 147), and this belief is illustrated as follows: "I assert the posssibility of the total banishment of instruments of restraint, and all other cruelties whatsoever" (p. 147). As is illustrated in Table 3, Hill, as Medical Superintendent at Lincoln, documented his experiences and supported his arguments for nonrestraint.

In this table one may observe that in the year 1829 more than half the inmates were restrained, while eight years later, in 1837, there were only two incidents of restraint out of 130 patients. Hill (1857) carefully described several patients who responded positively to the removal of mechanical restraint and attention to personal cleanliness: the availability of water; the ventilation of rooms; the heating of apartments by open fires; and the watchfulness of tall, strong, active attendants. He concluded by noting that "medicine is of little avail" and "moral treatment with a view to indure habits of self-control, is all and everything" (p. 167).

Table 3

Nonrestraint at Lincoln

Year	Total no. in the house	Total no. of patients restrained	Total no. of instances of restraint	Average no. of hours under restraint
1829	72	39	1,727	11.83
1830	92	54	2,364	11.47
1831	70	40	1,004	10.79
1832	81	55	1,401	11.19
1833	87	44	1,109	10.82
1834	109	45	647	10.20
1835	108	28	323	8.90
1836	115	12	39	8.57
1837	130	2	3	9.33

The publication in 1856 of Conolly's Treatment of the Insane Without Mechanical Restraint marked the culmination of Conolly's efforts to introduce the "Non-Restraint System" (p. 2) of patient care at Middlesex Asylum, Hanwell, Middlesex, England. Referring to the prevalent cruelty and neglect in the "lunatic asylums" of the last century and their continued presence in the present day, Conolly urged that this period "not be forgotten" (p. 2). He expressed strong feelings about the evils of restraint:

> As the restraint system comprehended every possible evil of bad treatment, every fault of commission and omission, so the watchful, preventive, almost parental superintendence included

> in the term non-restraint, creates guards against them all. For such is its real character, if properly understood and practiced. It is, indeed, above all, important to remember, and it is the principal object of this work to explain, that the mere abolition of fetters and restraints constitutes only a part of what is properly called the non-restraint system. Accepted in its full and true sense, it is a complete system of management of insane patients, of which the operation begins the moment a patient is admitted over the threshold of an asylum. (p. 35)

In Conolly's (1856/1973) view, "whilst in the old asylums every arrangement was principally made for security and control, in the new, every arrangement is made for the cure of the malady, or the comfort of the insane" (p. 53). In his Sixth Report (1844), Conolly noted that

> five years having now been completed since the abolition of the use of the strait-waistcoat, the muff, the leg-locks and handcuffs, the restraint chair, and every other form of mechanical restraint in the asylum, without the occurrence of any accident which the ordinary application of such modes of restraint could have prevented, and with a marked improvement in the character of those parts of the asylum in which they were in continual use, I should not think it necessary to say more on this subject than that my confidence in the practicability, safety, and advantages of the non-restraint has gained strength by every year's experience. (p. 253)

In his book Chapters in the History of the Insane of the British Isles, Daniel Hack Tuke (1882) noted that a "citizen of York--William Tuke" (his great-grandfather)--proposed in 1792 "that an institution should be erected where there should be no concealment, and where the patients should be treated with all the kindness which their condition allowed" (p. 113). For this humanitarian reformer, it became a question of humanity and right, and he resolved that there should be an asylum "openly conducted and on humane principles" (p. 113).

Tuke (1882) supported his argument for more humane treatment of the mentally ill by quoting a review of the York Retreat by one of the founders of the Edinburgh Review, Sydney Smith (April 1814):

> The great principle on which it appears to be conducted is that of kindness to the patients. It does not appear to them [the managers]. because a man is mad upon one particular subject, that he is to be considered a state of complete mental degradation, or insensible to the feelings of kindness and gratitude. (p. 124)

Tuke (1882) clinched his argument for nonrestraint with an additional admonition from Smith (1814):

> When a madman does not do what he is bid to do, the shortest method, to be sure, is to knock him down; and straps and chains are the species of prohibitions which are the least frequently disregarded. But the Society of Friends seems rather to consult the interest of the patient than the ease of his keeper, and to aim at the government of the insane by creating in them the kindest disposition towards those who have the command over them. Nor can anything be more wise, humane, or interesting than the strict attention to the feelings of their patients which seems to prevail in the institution. (Smith; cited in Tuke, p. 125)

In addition to giving credit to his great-grandfather, William Tuke of York, Daniel Tuke (1882) recognized the "experiment" in nonrestraint carried on by Dr. Charlesworth, visiting physician, and Mr. R. Gardiner Hill, house surgeon at the Lincoln Asylum. Supporting the work of these two innovators, Tuke stated:

> It must be mentioned that the entries of the visitors and the reports of the physicians alike agree on describing the condition of the patients as much improved, the quiet of the house increased, and the number of accidents and suicides as materially reduced in number. (p. 205)

While the beliefs of Pinel (1792), Hill (1857), Conolly (1856), and Tuke (1882) with regard to humanitarian treatment were implemented in a few places, the vast majority of asylums retained punitive attitudes toward the mentally ill and the custodial procedures suggested by such attitudes.

The North American scene. The asylums developed in North America generally reflected European trends. Deutsch (1960) credited Pinel

(1792) with having more influence on the European continent and Tuke (1882) with influencing developments in America. Deutsch noted that,

> of the eight mental hospitals that sprang up in the United States during the first quarter of the nineteenth century, the establishment of two was directly inspired by the successful operation of the York Retreat, and the administration of at least two others was patterned after that in effect at the Retreat. (p. 95)

In America, according to Braceland and Stock (1966), the beginning of the nineteenth century heralded the development of the mental hospital "to get the mentally ill out of prisons and poorhouses, garrets and cellars, and into places in which there would be some semblance of human consideration and in which patients would be protected during their illness" (p. 24). Justifying their belief that treatment within the family would fail and the patient in hospital was "beyond the reach of all these causes of excitement" (p. 137), Rothman (1971) declared that the first priority of the asylum program was to remove the patient, at the first sign of illness, from the community. In his text The Discovery of the Asylum, Rothman maintained that the "cult" of asylums which swept America in the late 1850s was not born of desperation or the last resort of a frightened community, but rather the belief that insanity was curable and the "asylum was a first resort, the most important and effective weapon in their arsenal" (p. 131). The proponents of the asylum system asserted that properly organized institutions would cure "almost every incidence of the disease" (p. 121). The superintendent of the Massachusetts Asylum declared that with appropriate treatment "a proportion of recoveries will take place as from any other acute disease of equal severity" (p. 131) and quoted his recovery rate as 82.25% of recent cases.

The development of the moral treatment movement in America was reflected in the following excerpt from a dissertation published in 1811 by Dr. T. Romeyn Back of New York (cited in Deutsch, 1937):

> MORAL MANAGEMENT. This consists in removing patients from their residence to some proper asylum; and for this purpose a calm retreat in the country is to be preferred: for it is found that continuance at home aggravates the disease, as the improper association of ideas cannot be destroyed. A system of humane vigilance is adopted. Coercion by blows, stripes, and chains, although sanctioned by the authority of Celsus and Cullen, is now justly laid aside. The rules most proper to be observed are the following: Convince the lunatics that the power of the physician and keeper is absolute; have humane attendants, who shall act as servants to them; never threaten but execute; offer no indignities to them, as they have a high sense of honour; punish disobedience peremptorily, in the presence of the other maniacs; if unruly, forbid them the company of others, use the strait waistcoat, confine them in a dark and quiet room, order spare diet . . . ; tolerate noisy ejaculations; strictly exclude visitors; let their fears and resentments be soothed without unnecessary opposition; adopt a system of regularity; make them rise, take exercise and food at stated times. The diet ought to be light, and easy of digestion, but never too low. When convalescing, allow limited liberty; introduce entertaining books and conversation, exhilarating music, employment of body in agricultural pursuits . . . ; and admit friends under proper restrictions. It will also be proper to forbid their returning home too soon. By thus acting, the patient will "minister to himself." (pp. 91-92)

Another writer, Caplan (1969), speculated about the mechanics of moral treatment:

> The essence of moral treatment was the belief that, because of this great malleability of the brain surface, because of its susceptibility to environmental stimuli, pathological conditions could be erased or modified by corrective experience. Therefore, insanity, whether the result of direct or indirect injury or disease, or of overwrought emotions or strained intellectual faculties, would be cured in almost every case. (p. 9)

Thus, the development of moral treatment, based on the belief that insanity was curable, was accompanied by the institutionalization of the insane. The system, according to Caplan (1969), resulted in its victims being removed

> to hospitals where they were provided with an individualized regimen of work and recreation, with religious and educational services, and with the supports and restrictions of group living. They were cared for by well-disciplined attendants and by a sympathetic, omnipresent superintendent, who attempted to cure them by both medicinal and "moral" or what would now be called psychological, means. (pp. 4-5)

The building of asylums in rural areas contributed to the isolation of all those associated with the institution. As land was cheaper in the rural areas and the adjacent towns would benefit from the increased income, this move was generally supported by the legislators.

The name Medical Superintendent is "especially apt" in Rothman's (1971) view, "for every detail of institutional design was a proper and vital subject for his consideration" (p. 134). Supporting the belief that rehabilitation of the mentally ill could be achieved through a "curative environment," the Medical Superintendent's focus became "the appropriate arrangement of the asylum, its physical dimensions and daily routine" (p. 134).

According to Caplan (1969), psychiatrists in the first half of the nineteenth century generally supported the idea that the physical and social environment played a role in mental health and illness. Just as sanitation of the physical environment was the goal of public health, "sanitation of both the physical and social environment became the goal of physicians concerned with alleviating and preventing mental illness" (p. 4).

The implementation of the values represented by moral treatment within the asylum resulted in an organization in which a fixed, disciplined, rigid routine was highly prized, and patients were kept busy with manual tasks. Rothman (1971) described this as follows:

> A precise schedule and regular work became the two chief characteristics of the best private and public institutions, and in the view of their managers, the key to curing insanity. The structure of the mental hospital would counteract the debilitating influences of the community. As one New York doctor explained, "the hours for rising, dressing and washing . . . for meals, labor, occupation, amusement, walking, riding, etc., should be regulated by the most _perfect precision_. . . . The utmost _neatness_ must be observed in the dormitories; the meals must be _orderly_ and comfortably served. . . . The physician and assistants must make their visits at _certain_ hours." Steady labor would also train inmates to proper habits, bringing regularity to disordered lives. "Useful employment, in the open air," explained the Vermont asylum superintendent, "affords the best moral means for the restoration of many of our patients." Luther Bell, head of the McLean Hospital, fully concurred: "_systematic, regular_ employment in useful body labor . . . is one appliance of moral treatment, which has been proved immeasurably superior to all others." Precision, certainty, regularity, order--these became the bywords of asylum management, the main weapons in the battle against insanity. (p. 145)

Whereas in Europe institutions were frequently converted monasteries, prisons, or almshouses, Americans were faced with having to build their own asylums. The architecture of the asylum, constructed in rural areas, reflected the belief that patients needed to be protected, and buildings were designed that were big and solid and would last. Rothman (1971) referred to a text by Thomas Kirkbride, Medical Superintendent of the Pennsylvania Hospital, in which he stipulated in great detail the proper size and location for the buildings, the materials to be used in construction, and the proper location of pipes and ducts, as well as how to occupy the inmates for the day. It would appear that in "settling these technical matters of construction and maintenance, he was confronting and solving the puzzle of curing insanity" (p. 134). This design, providing an environmental solution, was imitated with few variations throughout the North American continent. This state of affairs was acknowledged by Deutsch (1960):

> Throughout the nineteenth century the mental hospital had preserved a strange and unhealthy isolation from the main streams of community life. Often situated in rural districts, it was at times difficult of access even by railroad in those days before the advent of the automobile and other modes of rapid transportation and communication broke down distances and drew rural and urban communities closer together. In more than one sense, the typical institution was aptly termed a "monastery of the mad." The fact of this physical isolation from the centers of social and scientific activities tended to create a corresponding feeling of cultural isolation in the medical staffs of mental hospitals, living hermit-like existences for long periods of time. (pp. 272-273)

Following a tour of North American asylums in 1884, Dr. D. H. Tuke (1885) published his findings in a text, The Insane in the United States and Canada. Of particular interest for purposes of this study are Tuke's findings on his visits to the asylums in Canada. In the Preface, Dr. Tuke provides some indication of what he found:

> It is a cause of regret that the condition in which he found certain asylums in Canada left him no alternative, consistent with truth, but to paint them in the colours in which they presented themselves to his view, while gladly admitting that there were bright lights as well as dark shades in the picture. (Preface, n.p.)

In concluding the Preface, Tuke remarks on a bill soon to be brought forward in the Canadian Parliament:

> It is to be hoped that a Bill that has been introduced into the Canadian Parliament respecting Lunatic Asylums in the Province of Quebec will, if passed, effect some good, but abuses will never satisfactorily be provided for as long as the present system is permitted to continue in force. Radical remedies will alone suffice to remove radical evils. (Preface, n.p.)

The Hospice des Alienes de St. Jean de Dieu, located at Longue Pointe, Quebec, seven miles from Montreal, raised many concerns for Dr. Tuke. Opened in 1876, the institution was run by the Soeurs de Providence "to maintain the lunatic poor" (p. 189). Escorted by the "Lady Superior," Tuke expressed pleasure with the neatness and cleanliness of the hall and reception room. He expressed deep concern that the head of the hospital was not a medical person "with competent knowledge of the treatment, moral and medical, of the insane, with undivided authority and responsibility inside the institution, although subject to the Government, aided by efficient medical inspection" (p. 200).

While Tuke (1885) found some of the dormitories clean and neat, he was clearly appalled at the conditions he found as he ascended to the top floors of the building. There he noted: "The rooms and galleries become more and more crowded, and look bare and comfortless" (p. 192). His response is indicated in the following: "The spectacle is one of the most painful character" (p. 193), and "I have rarely, if ever, seen anything more depressing than the conditions of the patients in those portions of the asylum at Longue Pointe" (p. 193). He observed the overcrowded conditions, rooms without windows, or rooms with a "guichet" in which a patient is "just able to protrude his head" (p. 194). Many of the patients were "restrained by handcuffs" (p. 194) made of iron or leather, or secluded in their "cells" (p. 194). Dr. Tuke urged the Province of Quebec to do something about these conditions and to provide the necessary accommodation and treatment for the insane poor. Tuke's remarks were supported by the Medico-Chirurgical Society of Montreal, on November 7, 1884, as evidenced in the following resolutions: "That this Society has even reason to believe that the statements contained in the Report of Dr. D. Hack Tuke, of London, England, upon our Provincial Lunatic Asylums, are, in every material respect, true and well-founded" (p. 205).

While the conditions at St. Jean de Dieu appalled Tuke (1885), he praised the efforts of Dr. Workman, who assumed the post of Medical Superintendent of the Toronto Asylum in 1853:

> Dr. Workman reformed the asylum; and, could an unvarnished tale be told of the condition in which he found, and of that in which he left it, no better tribute could be paid to his character and work during the period of his superintendence. (p. 215)

The Decline of the Institutions

While "moral treatment" characterized the mental hospitals of the early 1800s, the influx of "foreigners" into America post-1860 saw the philosophy of moral treatment replaced by a belief in mass incarceration at the lowest per capita cost. In Caplan's (1969) view, the prime factor in the movement away from moral treatment and the growth of custodial care was "the acceptance of the fact that asylums could no longer be devoted almost exclusively to active therapy and cure of recent cases but had to provide, instead, a sheltered environment for chronic misfits" (p. 49). To keep up with the demand, hospital construction was increased, resulting in increased costs for maintenance. The growing number of chronic patients, the increase in immigrant paupers, and public attitudes about the rising costs of maintaining the insane resulted in inadequate funding for the institutions.

Two outstanding Americans brought to the attention of the public the deteriorating conditions in mental hospitals. Dorothea Lynde Dix (1802-87), a Boston school teacher, suffered recurring attacks of tuberculosis and, having been forced into retirement, began to teach in a women's prison. As Dix became acquainted with the deplorable conditions in the asylums, almhouses, and jails, she began a campaign in 1841 that aroused public awareness of the inhumane treatment of the mentally ill. Her efforts were instrumental in establishing 32 mental hospitals in the United States alone. Her influence was not confined to the United States, and she is rightly given credit for improving conditions for the mentally ill worldwide (Coleman et al., 1980, p. 45).

The pioneering work of Dix in educating the public about mental illness was followed by that of Clifford Beers (1908), a Yale graduate, who, having experienced a mental collapse, described his recovery and treatment in A Mind That Found Itself. Beers' vivid descriptions of the staff's punitive attitudes toward patients and his experience in a strait jacket--widely used to "quiet" patients--brought to the attention of the public the inhumane conditions present in the asylums. Receiving support from lay and professional people, Beers was instrumental in founding the present mental-health movement.

In Canada, Clarence Meredith Hincks founded the Canadian National Committee for Mental Hygiene in 1918. Earlier (1917), he had met Clifford W. Beers, the founder of the United States National Committee for Mental Hygiene. Both of these organizations were dedicated to improving conditions in the asylums of North America. Dr. Hincks is referred to in the Canadian Encyclopedia as "physician, mental-health reformer" (p. 988).

For Leighton (1982) the seeds of destruction of mental hospitals were sown in the movement itself, particularly the belief that "mental illnesses were curable, that the environment was all-important and that mental hospitals could be created so as to provide a therapeutic environment" (p. 18). Other factors identified by Leighton as contributing to the decline of these institutions were the rise of theories of biological determinism and the use of spiritualism accompanied by questions about traditional religious beliefs. This writer claimed that biological determinism had "a strong appeal to political leaders and policymakers. It provided them with formidable justification for denying funds to mental institutions" (p. 21).

Rothman (1971) noted that "the organizing concepts of the asylum," with its emphasis on physical structure, "encouraged a custodial operation" (p. 270). The post-1850 inflationary cycle with escalating costs for construction and maintenance of patients resulted in a severe shortage of funds for institutions. Added to this was the founding ideology of the institutions which placed high value "on traits like obedience, respect for authority, and regularity" (p. 270).

Historically, a succession of movements has characterized the development of treatment facilities for the care of the mentally ill. Leighton (1982) identified these movements as "moral treatment, mental hospital development, mental hygiene, psychoanalysis, child guidance and in our own time community mental health" (p. 2). Each of these movements was characterized by high levels of expectations and modest levels of achievement.

Initially, the development of mental hospitals for the care and treatment of the mentally ill was accompanied by more humane treatment. The lack of funds, increasing admissions, and public apathy resulted in the decline of moral treatment and the rise of custodialism.

Summary

The literature review of change in organizations illustrates the complexity and the importance of the concepts of adaptation and change in all organizations. Writers have developed several models and strategies for analyzing the change process in organizations. The models presented for discussion in this chapter reflect the different theoretical perspectives of the various writers in organizational change.

The development and evolution of mental hospitals concludes this chapter. Mental hospitals were initiated with great enthusiasm in response to the deplorable conditions of the mentally ill found in poorhouses and jails. Studies of mental hospitals generally reveal that, as organizations, they tend to develop rigid authoritarian structures, resulting in feelings of hopelessness in staff and patients. The repressive atmosphere created in these institutions is not conducive to therapeutic interventions. Faced with overcrowded conditions, lack of funds, lack of personnel, or poorly trained staff, mental hospitals became "warehouses" for humanity and, for many, a symbol of man's inhumanity to man.

Chapter 3

Leadership and Organizational Culture

The focus of this chapter is on a review of the literature on leadership and organizational culture. It begins with an examination of the concept of leadership as viewed by major theorists and investigators in the field. Different perspectives on leadership and definitions of leadership are explored. The second section presents an exploration of the concept of organizational culture. This chapter concludes with a discussion of the culture of the mental hospital.

The Concept of Leadership

Leadership, a phenomenon of universal interest and concern, has attracted attention throughout history. Countless questions revolve around the concept of leadership. Is it an innate characteristic or learned behavior? Who can be a leader? Is there a special style one may cultivate to become a leader? Is a leader born or made, or is leadership the end result of an active combination of nature and nurture? The mere mention of names such as Lincoln, Churchill, and Kennedy instantly evokes strong feelings associated with charismatic leaders. And the question asked at one time or another by perhaps most individuals is, "Do I have leadership qualities?" In Handy's (1981) view, the search for definitive answers to the leadership question "has proven to be another endless quest for the Holy Grail in organization theory" (p. 88).

Although the concept of leadership is an abstraction, many definitions and several models have been proposed to help us understand its essential elements. Chemers (cited in Kellerman, 1984) divided the literature on leadership into three major periods: the trait period, from 1910 to World War II; the leader behavior period, from World War II to the 1960s; and the contingency period, from the 1960s to the present. Other writers have categorized the literature into trait, behavior, situational, and participative (Johns, 1988); or trait, behavior, and contingency-situational (Swansburg, 1990).

According to Hollander (1964), the term leader "denotes an individual with a status that permits him [or her] to exercise influence over certain other individuals and is best seen within the framework of group process" (p. 16). Hollander recognized that leaders operate within a group context and receive status from followers and that task competence will increase the leader's influence with and acceptance by followers. Leaders who do not meet the needs of the group members will lose credibility and respect and will be replaced.

Three major meanings of leadership in the social science literature were identified by Katz and Kahn (1966): "as the attribute of a position, as the characteristic of a person, and as a category of behavior" (p. 301). They emphasized the relational component of leadership, for without followers no leader will emerge. Katz and Kahn considered the "essence of organizational leadership to be the influential increment over and above mechanical compliance with the routine directives of the organization" (p. 302). The need for leadership in organizations, even in those which have reached a state of maturity, is related to the imperfections of organizational charts, the interactions of the organization with its changing external environment, the changing internal dynamics of the organization, and the fact that the human beings who fill particular roles in the organization are also members of other organizations, with resultant demands on their energies. These other affiliations may affect their behavior in the organization that employs them, necessitating some kind of adaptive change within the organization.

Three problems with the concept of leadership were posed by Pfeffer (1977): "(a) ambiguity in definition and measurement of the concept itself; (b) the question of whether leadership has discernible effects on organizational outcomes; (c) the selection process in succession to leadership positions" (p. 104). Pfeffer was interested in leadership primarily as a phenomenological construct and commented that, despite extensive research on leadership, "the dimensions and the definition of the concept remain unclear" (p. 105). For this author, the challenge was to distinguish leadership as a separate concept from other processes of social influence. Leaders are, in Pfeffer's analysis, embedded in complex social systems, and the tendency of human beings is to attribute outcomes to persons rather than to focus on forces outside the leader's control. Pfeffer held the view that the effect of leadership behavior on the organization may be small because leaders are expected to conform to a set of appropriate behaviors and have little real control over resources and policies.

Another writer, Bons (1981), noted the confusion that arises among people in a discussion of leadership. He cited the work of Stogdill (1974) who, in his extensive review of leadership literature, used 10 pages to document the numerous definitions of leadership. In any discussion of leadership, it is important that the communicators clarify their particular definitions of leadership. Bons distinguished the term leadership, which he defined as "a process of influencing human behavior" (p. 1:7), from organizational leadership, defined as "the process of influencing human behavior so as to accomplish the goals prescribed by the organizationally appointed leader" (p. 1:8). His justification for this stance was that simply defining leadership does not take into account the full significance of the goal orientation of organizations and the responsibility of the leader in accomplishing these goals.

Viewing leadership as both an interpersonal process and a social phenomenon, Chemers (cited in Kellerman, 1984, p. 92) examined the process of interpersonal influence which takes place in small groups. Since leadership is influenced by the situational context in which it takes place, the social, economic, and cultural characteristics of an organization will affect the functioning of the leader. On the basis of an examination of the trait, behaviors, contingency, transactional, cognitive, and cross-cultural approaches to the study of leadership, Chemers concluded:

> We can now look back on over seventy years of scientific research on leadership in small groups. For much of that time the literature has been characterized by false starts, dead ends and bitter controversies. Even today, the study of leadership is consistently confronted with acrimonious debates among theorists, giving the field an appearance of chaotic disarray. (p. 105)

In one of his early works Bennis (1959) commented on the lack of consensus about leadership and the proliferation of studies in the area.

> Of all the hazy and confounding areas in social psychology, leadership theory undoubtedly contends for top nomination. And ironically, probably more has been written and less known about leadership than about any other topic in the behavioral sciences. Always, it seems, the concept of leadership eludes us or turns up in another form to taunt us again with its

> slipperiness and complexity. So we have invented an endless proliferation of terms to deal with it. . . . and still the concept is not sufficiently defined. (p. 259)

Trait or great man approach to leadership. Early research on leadership effectiveness focused on the traits of the leader. It emphasized inherent personal qualities such as intelligence, dependability, tolerance of stress, social maturity, and high energy levels.

Stogdill's (1974) review of over a hundred studies from 1904 to 1947 revealed that 15 or more of the studies surveyed reported that the average person who occupied a leadership position exceeded the average member of his group in five characteristics: "(1) intelligence, (2) scholarship, (3) dependability in exercising responsibility, (4) activity and social participation, and (5) socioeconomic status" (p. 65). In addition, Stogdill reported that a person achieved leadership status through participation in group activities and demonstrating the ability to expedite the work of the group. Stogdill concluded that a person does not become a leader by virtue of a combination of personal traits, "but the pattern of personal characteristics of the leader must bear some relevant relationship to the characteristics, activities and goals of the followers" (p. 66). A person who is a leader in one situation may not necessarily be a leader in other situations.

Numerous authors (Bons, 1981; Burns, 1978; Handy, 1981; Vroom & Yetton, 1973) have criticized the trait approach to the study of leadership, particularly on the grounds that in many studies very few similarities were found in the traits of the leaders. Work is still being done in this area, as is indicated by Bennis and Nanus's (1985) text and Bennis's (1989) study. The issue of the relationship between traits and leadership is still alive. In a series of interviews with 90 successful leaders, Bennis and Nanus (1985) identified four areas of competence embodied in these successful leaders: The first area was attention through vision, meaning that leaders are results oriented. The second was meaning through communication, the ability to induce enthusiasm and commitment in others through the communication of vision. The third area was management of trust through positioning (p. 26). Bennis and Nanus concluded that "trust is the glue that maintains organizational integrity" (p. 44). In their study, leaders were careful to make themselves known and their positions on issues clear. The fourth type of skill was the deployment of self through positive self-regard and the Wallenda factor. Benus and Nanus noted that these leaders were successful through the "creative deployment of self" (p. 56), they were aware of their weaknesses, and they knew their worth. The leaders in this study, through their own positive self-regard, created positive self-regard in their employees. The Wallenda factor is related to the ability of leaders to "put all their energies into their task" (p. 69) and to focus on positive future goals, not on past errors.

Although Bennis (1989) was not overly optimistic about the situation in which leaders find themselves, he offered suggestions. To avoid disaster during periods of change, Bennis suggested that leaders should "recruit with scrupulous honesty" (p. 147); "guard against the crazies" (p. 148); "build support among like-minded people" (p. 148); "plan for change from a solid conceptual base" (p. 148); "don't settle for rhetorical change" (p. 149); "don't allow those who are opposed to change to appropriate basic issues" (p. 149); "know the territory"

(p. 149); "appreciate environmental factors" (p. 150); "avoid future shock" (p. 150); and "remember that change is most successful when those who are affected are involved in the planning" (p. 150).

Leadership styles/attitudinal approaches. The development of behaviorism in psychology and the growing disenchantment with the trait approach led to deeper investigation of leadership behavior. Researchers began to focus not on the traits of the leader, but on the behavior style of the leader. Lewin (1948) reported on the classic study which he and Lippitt conducted at the Iowa Child Welfare Research Station. Students were divided into two groups, each with an adult leader. Democratic and authoritarian atmospheres were created. The observers noted that "the autocratic leader put forth twice as much action towards the members as the democratic leader" (p. 76). Lewin's studies of three leadership styles--democratic, autocratic,and laissez-faire--found that "the autocratic atmosphere gives a much greater and more aggressive dominance of the leader, and a narrowing down of the free movement of the members, together with a weakening of their power fields" (p. 77).

For many years, Likert (1967) and his colleagues at the Institute for Social Research, University of Michigan, studied leadership styles and organizational effectiveness. Organizations were characterized as having one of four types of management systems: System 1--exploitive-authoritative: Managers are autocratic, limit decision making to the top, and use fear and punishment; System 2--benevolent-authoritative: Managers have a patronizing confidence in subordinates; System 3--consultative: Managers have some trust and confidence in employees, engage in two-way communication, and make use of subordinates' ideas and opinions; and System 4--participative group: Managers have complete trust and confidence in employees and employ the ideas and opinions of employees constructively (pp. 14-24).

Likert (1967) developed a standardized diagnostic questionnaire, "Profile of Organizational Characteristics," which encompassed seven variables: leadership, motivation, communication, interaction-influence, decision making, goal setting, and control and performance goals (pp. 4-10). Survey feedback techniques were devised resulting in action plans that would move the organization toward System 4 (the participative style of leadership). Working with the Harwood Manufacturing Company, a leading firm in the pajama industry, Likert and his colleagues introduced changes that were intended to move the company toward System 4. These changes included "an earnings development" training program for employees, training of managers and supervisors in the principles and skills required by a system of management working toward System 4. Measurement showed that the changed management system toward System 4 "resulted in substantial increases in productivity" (p. 37). According to Likert, with the implementation of System 4, designed around group methods of decision making and accountability, "the performance record of each manager and each member of the work group helps to make clear the contribution of each to the success of the total enterprise" (p. 188).

At Ohio State University researchers interested in effective leader behaviors developed the Leader Behavior Description Questionnaire (LBDQ). This instrument was designed to measure the leader's "consideration for workers" and "initiating structure."

> Consideration reflects the extent to which the leader is likely to have job relationships characterized by mutual trust, respect for subordinates' ideas, and consideration of their feelings. Initiating structure reflects the extent to which the leader is likely to define his role and those of his subordinates toward goal attainment. (Bons, 1981, p. 13:6)

Contingency/situational theories. The research in leadership styles and attitudinal approaches of leaders neglected to explore the situation in which they found themselves. The following writers are generally considered to have focused on the situation of the leader.

Fiedler (1972) attempted to integrate situational factors into his work on leadership. He proposed that leadership effectiveness was related to the group members' perception of the leader. The contingency model proposed by Fiedler "postulates that leadership effectiveness depends upon the appropriate matching of the individual's leadership style of interacting and the influence which the group situation provides" (p. 247). In his research, Fiedler employed a scale consisting of 16 items called the Least Preferred Co-Worker Score (LPC). The leader was asked to think of people with whom he or she had worked and to describe their least preferred co-worker. Fiedler's research showed that task-oriented leaders were effective in group situations that were either very favorable or very unfavorable for the leader. A leadership style which is more relationship oriented is effective in situations of intermediate favorableness. Fiedler maintained that

> if leadership training is to be successful, . . . it should focus on providing the individual with methods of diagnosing the favourableness of the leadership situation and for adapting the leadership situations to the individual's style of leadership so that he can perform effectively. (p. 254)

The normative decision-making model presented by Vroom and Yetton (1973) explored the relationship between leadership and decision making, particularly the leader's decision to allow subordinates to participate in the problem-solving process. Two sets of questions guided this research. The first was the normative question of what process should be employed by the leader in decision making to be effective. The second involved the descriptive question of the leader's decision-making process.

Vroom and Yetton's (1973) model was based on the hypothesis that there is a positive relationship between workers' productivity and their participation in decision making. This research focused mainly on group problems, and a set of rules was developed to guide leaders "in determining the form and amount of participation in decision making by subordinates in different classes of situations" (p. 11). Vroom and Yetton (1973) suggested that, to be effective, leaders must match the problem situation with an appropriate decision-making process. They maintained that leaders would be more effective if in situations that did not affect subordinates they were more autocratic. Similarly, in situations where subordinates' co-operation is essential, it is important for leaders to use participative decision-making processes. Vroom and Yetton reported that the normative model was "explicitly founded on the assumption that the effectiveness of an organizational decision is a joint function of situational variables expressed as problem attributes and leader behavior expressed as processes for making decisions" (p. 204).

Increasing competition in business, technological development, diversification, globalization, and political uncertainties have been identified by Kotter (1988) as some of the difficulties in providing effective leadership in modern society. Kotter's thesis is that the corporations of today are not prepared for the increasing needs for leadership and the challenges leaders face in the future. Leadership is needed not only at the Chief Executive Officer level, but also increasingly in all managerial positions. Kotter declared that for the rest of the century the world of business will be characterized by intense competition in complex organizations. He stated further that, while limited leadership and strong management may work very well in prosperous times, "in times of chaos, strong leadership with some limited management may be what is required" (p. 24).

In spite of all the research on leaders and leadership, many questions remain unanswered, and more research is needed in the area of organizational performance and leadership.

Organizational Culture

The culture of the organization, its beliefs, values, taboos, and view of the world, will affect the ability of the organization to adapt and implement change. Change will be difficult to implement in any organization where the norms and values support traditional beliefs. Since every organization expects people to fit in, people need to learn and observe the cultural norms of an organization. Knowledge of the organization's culture promotes understanding of organizational life and is necessary for the survival of new managers.

Recognizing that modern organizations operate in a climate of turbulence and rapid change, del Bueno and Vincent (1986) asked the question, "Organizational culture: How important is it?" Culture is defined by these authors as

> the combination of the symbols, language, assumptions and behaviors that overtly manifest an organization's norms and values. It is the taken-for-granted and shared meanings people assign to their social surroundings that can have a profound effect on an organization's decision making and performance. Culture includes both implicit and the explicit contracts that include what is expected of members and the rewards or sanctions associated with compliance or non-compliance. (p. 15)

Policies and practices reflect the cultural norms and values of the organization.

The basic assumptions that form the cultural foundation of the organization are the metaphors used to describe the organization. Metaphors may be militaristic; for example, "we run a tight ship here" (p. 17). Military metaphors indicate an organization where employees are the foot soldiers, and the leaders are chiefs. In contrast with military metaphors, organizations characterized by the use of sports metaphors where the group "is referred to as the team" (p. 17) tend to value team work and activities that focus on team building.

del Bueno and Vincent (1986) stressed that it is important for newcomers to uncover the underlying values and assumptions in the organization. This includes discovering "the sacred cows and taboos, the people, beliefs, or things that cannot be discussed, attacked or ignored" (p. 18). In obtaining this information, the new administrator may avoid mistakes related to not knowing the score.

The need to elucidate the concept of "organizational culture" and to demonstrate the relationship between the problems of leadership and the culture of an organization were the focus of Schein's (1985) text, Organizational Culture and Leadership. Culture for this researcher is "a deep phenomenon" (p. 5); it is complex and not easy to understand, "but the effort to understand it is worthwhile because much of the mysterious and the irrational in organizations suddenly becomes clear when we do understand it" (p. 5).

Schein (1985) explored the many meanings given to the concept of culture by various writers, and he agreed that often these meanings do reflect the organization's culture. However, in his view, many writers failed to get at the deeper levels of shared basic assumptions and beliefs in the organization. Culture, in Schein's view, is defined as

> a pattern of basic assumptions--invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration--that has worked well enough to be considered valid, and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (p. 9)

Three levels of culture were identified by Schein (1985): artifacts and creations, values, and basic assumptions. He distinguished the essence of culture--the basic assumptions--from the observed manifestations of the culture--the values and behavior.

To understand the organization and its members, Schein (1985) observed that it is necessary to demystify the concept of culture and to analyze its dynamics. The culture that develops in a particular organization enables the organization to function, and, in Schein's view, "culture not only solves external survival and internal integration problems, but, once acquired, also reduces the anxiety inherent in any new or unstable situation" (p. 83). Thus, not only will the actions of leaders create organization culture, but also the culture may be strengthened and embedded by leaders. For Schein, "the endless discussion of what leadership is and is not could, perhaps, be simplified if we recognized that the unique and essential function of leadership is the manipulation of culture" (p. 317).

In mature organizations the development of a particular culture may inhibit the organization's adaptation to environmental realities. A new leader who can manage culture change may be required for organizational survival. Schein (1985) viewed leadership as needed for organizational adaptation and survival. If the culture of the group does not change to meet changing conditions, then the group will "disappear as a social entity" (p. 322). Operating from within the organization, the new leader will need perception and insight, motivation and skill, emotional strength, the ability to change the cultural assumptions of the group, the ability to involve the group as it seeks change, and the vision to discern the deepest assumptions of the group.

The Culture of the Mental Hospital

Studies (Dunham & Weinberg, 1960; Solomon & Patch, 1971) of mental hospitals have indicated the development of cultures which are antitherapeutic, resulting in the isolation of staff and patients and the development of routines which lead to the subjection and control of patients and few opportunities for social interaction between male and female patients.

Interviews with all levels of employees and patients and participant observation were undertaken by Dunham and Weinberg (1960) in their study of a large state mental hospital. The study focused on the culture and social structure of the organization and its effects on patients and staff. These researchers viewed the hospital as a network of personal relationships.

Dunham and Weinberg (1960) contrasted their view of the mental patient with that of the psychiatrist. The medical approach was to view the patient as a discrete individual whose symptoms were observed, analyzed, and fitted into a diagnostic category. The researchers viewed patients as people whose behaviors may deviate from the conventional norm in society, but who still have segments of their personalities which are organized, allowing them to participate socially. The orientation of the researchers in conducting this study is expressed in the following quotation:

> Every social institution develops its particular culture and social structure. But the character of the social structure of the mental hospital differs in its significance from that of other social institutions. This is so because approximately 75 percent of the persons constituting this social structure have mental disturbances which require care and treatment for uncertain periods of time. It becomes extremely important, therefore, to analyze carefully this hospital milieu for elements which may adversely affect certain disorders and hence impede the recovery of some patients. Consequently, in this book we have attempted to describe what the mental hospital actually is rather than what it pretends to be. (p. 3)

Dunham and Weinberg (1960) discussed the traditional culture of the mental hospital where patients are punished for an infraction of hospital rules. Although the tradition of punishing the insane probably predates the development of mental hospitals, they found that punishment of patients was still practised. "Agitated" patients were those inmates who had violated the hospital norms and "as deviants, must be excluded from participation in the general hospital milieu" (p. 132). The "custodial" group of patients may have attempted to escape, "have persistently disobeyed or defied attendants or other hospital employees, or have harbored homicidal intentions to certain members of the community" (p. 132). Punishment included isolation, neglect, the development of strict rules and regulations which would cause a normal person to rebel, the use of strait jackets and seclusion, and beatings.

Dunham and Weinberg found that the living arrangements for patients in the mental hospital were such that a normal person would have difficulty adjusting to them. Privacy was a luxury not afforded to patients, as eating, dressing, toileting, and sleeping were completed under the watchful eyes of the staff.

The general apathy and hopelessness of the patients on a female ward were described as follows:

> The majority were seated and were somehow eager for the attention of the visitors. They were dishevelled, dressed in wide, loose dresses. One elderly woman walked about semi-nude, her arms folded as if in assertive defiance. A piercing shriek mingled with cursing was heard at the far corner of the porch. A large Negro woman launched a vigorous effort to loosen herself from the iron anklets and in violent rage shouted and banged her hands on the bench. Her shouting caused a wave of excitement which swept over some of the other patients, causing them to mumble more hastily and more loudly to themselves. Others, however, persisted in their apathy. (Dunham and Weinberg, 1960, p. 135)

The traditional role of the state mental hospital as described by Solomon and Patch (1971) provided insights into its culture:

> Until recent years, the major task of the state hospitals was the physical care and control of its inmates. Acute personnel shortages imposed a pyramidal system of authority in the interest of efficiency. The patients' direct contacts were principally with the aides, who reported to the nurses, who reported to the physicians, who reported to the superintendent. Orders involving all aspects of the patient's life came from the superintendent down through the various echelons and finally to the patient. (p. 143)

The values expressed through this pyramidal hierarchical structure were maintained in an authoritarian atmosphere, where orders were not questioned and obedience from staff and patients was the norm. Rewards could include "special privileges" for those patients who were quiet and docile and who contributed to the work of the ward or hospital; for example, weekly issues of tobacco or town privileges. For those who did not conform, punishment included isolation, the use of the strait jacket, or seclusion. Solomon and Patch found that on admission to the mental hospital, the new patient received what little therapy was available, considering the overcrowding, lack of trained staff, and shortage of funds. If the patient's response was slow or, in the view of the staff, no noticeable improvement was observed, the patient would be moved from the admission service to the "rehabilitation" wards. This euphemism for the chronic wards was a clear message to the patient and his relatives that he would remain in hospital for a long time. On the chronic wards there were few staff, and the patient would be assigned to work in one of the hospital service areas--laundry, kitchen, or hospital gardens. The culture in the chronic wards was characterized by routinization, regimentation, and hopelessness.

Other studies and writers (Sommer & Dewar, 1963; Stotland & Kobler, 1965; Wing, 1967) documented the antitherapeutic culture found in the majority of mental hospitals. These studies found considerable evidence to support the view that the situation found in mental hospitals results in great difficulties in establishing a humane and therapeutic climate, leads to the deterioration of the patient, and hinders rehabilitation.

The culture of any organization is therefore an important consideration in understanding how the organization works and must be considered by leaders seeking to bring about change. If the implementation of change is to be successful, the leader must be aware of the values, beliefs, and norms which guide the day-to-day interactions of the members of the organization.

Chapter 4

Research Design and Methodology

The focus of this chapter is on the research design and methodology of the study. Following the introduction, the first section addresses the research design, the case-study approach. This is followed by an examination of the nature of qualitative research. Included in the third section is a description of the interviewees for each of the three case studies. Reference is made to the documents and records that were obtained through the Public Archives of Alberta and the Alberta Hospital Museum. Consideration of the methodologies utilized and the standards of rigor applied in carrying out the research concludes the chapter.

Although there are many paradigms available to those who seek "the truth about the world," the scientific and the naturalistic are the most widely used. The scientific paradigm views truth as confirmable, and the fundamental technique is experimentation. In contrast, the naturalistic paradigm relies mainly on field study as its fundamental technique and views truth as inevitable or inescapable. Lincoln and Guba (1985) posited that paradigms "represent a distillation of what we think about the world (but cannot prove). Our actions in the world, including actions that we take as inquirers, cannot occur without reference to those paradigms: 'As we think, so do we act'" (p. 15).

In a comparison of the scientific paradigm (based on a logical positivist epistemology) and the naturalistic paradigm (based on a phenomenological epistemology), Guba and Lincoln (1987) identified three basic assumptions: "the nature of reality, subject and object dualism, and the nature of truth statements" (p. 62).

The nature of reality: The focus of the scientific inquirer is the discovery of variables and a description of "their relationship primarily for purposes of prediction and control" (Guba & Lincoln, 1987, p. 56). In contrast, the naturalistic inquirer seeks to uncover multiple realities, for "phenomena do not converge into a single form, a single 'truth,' but diverge into many forms, multiple 'truths'" (p. 56).

Subject-object dualism: In the area of physical science there is almost "no interaction between investigator and investigated object" (Guba & Lincoln, 1987, p. 59), whereas in the naturalistic paradigm, the inquirer is the data-collection instrument, and "there is no guarantee that when information is collected from human subjects, by whatever method, that there will not be interaction between those subjects and the minds that determined what information to collect and how to collect it" (p. 60).

The nature of "truth" statements: The notion of "enduring truth value . . . unchanged from context to context" (Guba & Lincoln, 1987, p. 58) is the aim of the researcher utilizing the scientific paradigm, while

> the naturalistic inquirer, given his view of multiple realities and the complex interactions that take place between an inquirer and the "objects" of an inquiry, tends to eschew generalizations in favor of "thick descriptions" (Geertz, 1973) and "working hypotheses" (Cronbach, 1975). (Guba & Lincoln, p. 58)

In an extensive analysis of the scientific and naturalistic paradigms, Guba and Lincoln (1987) concluded that the naturalistic paradigm "is the more useful for all social-behavioral inquiry" (p. 56) and "the method of choice when dealing with human behaviors" (p. 63).

In support of the positions described above, data were gathered from the participants and interpreted from the Selznick (1957) perspective in order to understand the process of adaptive change and the role of leadership in implementing change. Utilizing interview techniques, the researcher acted as the "data collection instrument" (Guba & Lincoln, 1987, p. 60). The multiple realities of the interviewees were explored, and the focus of the inquiry was on "thick descriptions" rather than on generalizations. Thus, this research lent itself to the naturalistic paradigm and the use of qualitative research strategies, with the case-study approach selected to examine the three critical events.

Research Design

In a selected review of the literature on case-study research, Merriam (1985) noted that definitions of the case study "are most often expressed in terms of its functions and appropriate uses" (p. 206). MacDonald and Walker (1975) defined a case study as "the examination of an instance in action" (p. 2); Bogdan and Biklen (1982) conceptualized the case study as "a detailed examination of one setting, or a single subject, or one single depository of documents, or one particular event" (p. 58). In the view of Goetz and Le Compte (1984), "case study analysis is appropriate for intensive, in-depth examination of one or a few instances of some phenomena" (p. 46); and Borg and Gall (1983) defined the case study as a "detailed examination of a single subject or group or phenomenon" (p. 488) in order to achieve "an in-depth understanding of the entity being studied" (p. 489). Yin (1984) distinguished case studies from other research strategies and provided a more "technical" definition:

> A case study is an empirical inquiry that:
>
> - investigates a contemporary phenomenon within its real-life context; when
> - the boundaries between phenomenon and context are not clearly evident; and in which
> - multiple sources of evidence are used. (p. 23)

According to MacDonald and Walker (1975), the case-study method is "the way of the artist" who, "through the portrayal of a single instance locked in time and circumstance, . . . communicates enduring truths about the human condition" (p. 3). Recognizing the social process involved in case-study research, these writers identified some of the problems faced by the researcher:

> - problems of the researcher's becoming involved in the issues, events, or situations under study;
> - problems over confidentiality of data; problems stemming from competition from different interest groups for access to and control over the data;
> - problems concerning publication, such as the need to preserve anonymity of subjects;
> - problems arising from the audience being unable to distinguish data from the researcher's interpretation of the data. (p. 5)

A possible weakness of the case-study method was raised by Mouly (1978) when he questioned the reliability of people's memories because case studies were "ex-post facto" research and a "fait accompli" (p. 259). This situation can lead to difficulties both in obtaining dependable data and in the correct interpretation of the data. Questioning the validity of this approach, Mouly maintained that it is a clinical procedure suitable for generating hypotheses which might be "verified by more rigorous investigation" (p. 260).

In contrast to the concerns raised by Mouly (1978), Stake (1978) noted that "case studies will often be the preferred method of research because they may be epistemologically in harmony with the reader's experience and thus to that person a natural basis for generalization" (p. 5). Stake challenged researchers to broaden the concept of "cases" from an individual person to whatever "bounded system" is of interest (p. 7): a program, a responsibility, a collection, or a population (p. 7). In Stake's view, the potential of the case-study method to add to experiential understanding of the human experience ensures that it will remain a popular method of inquiry (p. 7).

The "potential to generate rich subjective data that can aid in the development of theory and empirically testable hypotheses" (p. 489) was the main reason given by Borg and Gall (1983) to support case-study research. They emphasized the need to collect extensive data to achieve in-depth understanding and criticized "shallow case studies" which, in their view, do not collect enough data to make useful contributions (p. 489).

After an extensive review of the literature, Merriam (1985) declared that, although most writers agree that the case-study method falls within the naturalistic orientation of research, few differentiate the case study from other qualitative research methods. For Merriam the differences lie in the end product, with the focus on an "intensive, holistic description and analysis of the phenomenon or social unit being studied" (p. 206) and "the natural setting in which the research takes place" (p. 206), and it is characterized by what Geertz (1973; cited in Guba & Lincoln, 1987) called "thick description" (p. 206).

> Thick description involves literal description of the entity being evaluated, the circumstances under which it is used, the characteristics of the people involved in it, the nature of the community in which it is located, and the like. . . . Thick description also involves interpreting the meaning of

> such demographic and descriptive data in terms of cultural norms and mores, community values, deep-seated attitudes and motives, and the like (p. 11a). (Merriam, 1985, p. 206)

Merriam proceeded to distinguish between studies labeled ethnography, grounded theory, and case study. He affirmed his definition of a case study: "If the final product is an intensive, thick description and interpretation of the phenomenon so that the reader understands the 'slice of life' (Wolf & Timitz, 1976-77) investigated, it is a case study" (p. 207).

In pursuing the general objective of the study, selected critical events or key turning points in the life of the hospital were analyzed. These pivotal events contributed significantly to redefining the institution's mission and role. External forces, internal pressures, shifts in values, and leadership factors were influential elements in the implementation of change. The selected events were the elimination of mechanical restraints (1928-36), the introduction of the tranquilizers (1953-57), and deinstitutionalization (1967-75).

Although these three critical events might be viewed as three separate case studies, the events are linked conceptually and, taken together, provide a description of the evolution of the organization over time. Consequently, the entire research project constitutes the case.

Methodology

Taylor and Bogdan (1984) defined the term methodology as "the way we approach problems and seek answers" (p. 1). The methodology chosen is, according to Taylor and Bogdan, influenced by the researcher's own assumptions and interests as well as by the purpose of research. These writers concluded that discussions about methodology are often "debates over assumptions and purposes, over theory and perspective" (p. 1).

The above comments are reflective of the position of this researcher, an employee at Alberta Hospital Ponoka for many years. Fascinated by the social processes within the hospital and the external pressures exerted on the hospital, the researcher perceived this study as a kaleidoscope which unfolded as data were collected and analyzed. The writer had been away from the hospital for seven years when the study was conducted, and the passage of time contributed to the ability of the writer to obtain an objective viewpoint.

Qualitative research, according to Bogdan and Biklen (1982), must take place in the "particular setting under study" (p. 27), which they label "the natural setting" (p. 27). Conducting research in this manner facilitates the ability of the researcher to understand "the context of the history of the institutions" (p. 27). This research was conducted at Alberta Hospital Ponoka. The interviewees were easily accessible, because many had retired in the Ponoka community and were willing to be interviewed. The reports and documents relevant to this research were obtained from the Alberta Hospital Museum or the Public Archives of Alberta.

Addressing the need to examine the purpose and credibility of qualitative research, Glaser and Strauss (1966) remarked that qualitative research "should be scrutinized for its usefulness as an end product" (p. 56). Three reasons were indicated for their support of qualitative analysis:

> First, it is more often than not the end product of research within a substantive area beyond which few, if any, researchers are motivated to move. Second, qualitative research is often the most 'adequate' and 'efficient' method

> for obtaining the type of information required and for contending with the difficulties of an empirical research situation. Third, sociologists (and informed laymen) manage often to profit quite well in their everyday work life from analysis based on qualitative research." (p. 56)

Evaluation of qualitative research, in Glaser and Strauss's view, must be based on criteria developed from the "generic elements of qualitative methods for collecting, analyzing, and presenting data and for the way in which people read qualitative analyses" (p. 56).

Cautioning those researchers who view qualitative and quantitative research as divergent or even contradictory, van Maanen (1979) noted that they are not mutually exclusive; rather, that the differences lie "in the overall form, focus and emphasis of study" (p. 520). The contrast lies in the focus of the qualitative investigator on the social process, while the quantitative researcher tends to focus on the social structure. The objective in qualitative research is "to describe, decode, translate or otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world" (p. 520). In keeping with the above comments by van Maanen, the focus of this research is on the social processes involved in the three critical events selected for analysis. Events are described in the interviewees' own words, and the meaning of these words was checked with the interviewees.

In defining the territory of qualitative research, Das (1983) recognized the difficulty in precisely defining qualitative methods, as they are "at best a pot-pourri of interpretive techniques" (p. 923). Accepting a wide variety of approaches for collecting data while emphasizing the holistic perspective in which conclusions tend to be impressionistic rather than definitive, Das maintained that

> qualitative research methodology combines the rational with the intuitive approach to knowledge; the focus in many qualitative studies typically is on the unfolding of process rather than the structure. Qualitative approaches lend themselves better to the production of serendipitous findings and are in many cases broader and more holistic in perspective than quantitative tools. (p. 923)

Field and Morse (1985) emphasized the importance of both the "emic perspective," often referred to as the "native's point of view" (p. 11), and the focus on process that builds theory step by step "over a period of time" (p. 11). Factors noted by Field and Morse which must be considered in determining methodology include the nature of the phenomena to be described, the maturity of the concept, constraints/confines from the subjects or setting, and the methodological threats to validity (pp. 13-15). As the interviewees had all worked at Alberta Hospital Ponoka, their responses to questions reflected their perceptions of the critical events under study, or what Field and Morse referred to as "the native's point of view" (p. 11).

Access to the Organization

In keeping with the advice of Field and Morse (1985) on the importance of both informal and formal contacts, access to Alberta Hospital Ponoka was gained through both informal and formal means. Initially, an informal meeting was arranged with the Executive Director to discuss the purpose of the research and to request the cooperation of management and staff. Informal approval was granted, and the researcher was requested to submit the formal proposal and present it for consideration by the hospital's Research and Ethics Committee. Formal approval was received shortly thereafter from the Executive Director (see Appendix 1).

Throughout the project, informal contact was maintained with both the Executive Director and the former Associate Executive Director of the hospital.

Data Sources

The major sources of data for this study were interviews, documents, and records.

Interviews

Mouly (1978), Patton (1980), Borg and Gall (1983), and Taylor and Bogdan (1984) referred to the interview as a common methodology in qualitative research. As it is not possible to observe another person's feelings, thoughts, or intentions, interviewing, in Patton's view, enables the researcher to understand the inner perspective of the other person. The techniques of interviewing assume that someone else can report in a meaningful way how "they have organized their world and the meanings they attach to what goes on in the world" (Patton, p. 196). Guided by the beliefs of Guba and Lincoln (1987) that interviewing is an "indispensable tool" (p. 155) and the "backbone" (p. 154) of the naturalistic-inquirer interview guides, research questions related to the three critical events were developed. These research questions served as a guide in which the interviewees were encouraged to share their recollections in their own words in a comfortable, conversational setting.

The research questions relevant to this study are:

1. What were the essential characteristics of selected critical events in the evolution of the hospital?

2. How were the organization's mission and role redefined as a result of important events in its development?

3. How did the organization shift its goals and priorities as a result of internal and external pressure?

4. What were the specific problems encountered as new policies were developed and implemented?

5. What was the leader's role in facilitating the adaptation of the organization to important events in its development?

According to Gorden (1980), the type of respondent needed "depends mainly upon the type of information sought" (p. 146). He suggested four basic criteria in selecting respondents: "Who has the relevant information? Of those having the information, which are physically and socially accessible? Which persons having the information are most willing to give it? Which persons having the information are most able to give an accurate accounting?" (p. 147). These criteria served as a guide in the selection of participants.

A total of 47 people were interviewed. At the conclusion of the first interview the person was asked to recommend others. This snowball sampling technique (Bogdan & Biklen, 1982) proved effective. The researcher was advised on several occasions, "Don't forget [names of persons]," and several names were mentioned.

News of the study spread in the Ponoka community, and several of the interviewees responded to the initial telephone call with, "Yes, I heard that you might be calling." Each potential participant was contacted by phone and given the following information:

- the general purpose of the research
- an explanation of the role of the interviewee

- an explanation of the confidential and anonymous nature of the interview
- a request to tape the interview
- an explanation of the voluntary nature of the research
- an explanation of the interviewee's right to refuse to answer questions

All those contacted willingly agreed to participate. Three especially stressed that they believed it important that the story of the hospital be recorded.

All interviews were conducted in an informal research manner and were tape recorded, with the interviewees given as much time as they wished to respond to questions. When interviewees would remember a point that related to an earlier question, they were free to backtrack and provide additional recollections. The interview guide served as a flexible format that invariably led to free and open communication. The role of the researcher usually became that of an interested listener who on occasion would reflect comments back to the participants in seeking clarification or further elaboration.

In taping the interviews, the researcher used a small recorder and microphone which were placed out of direct sight of the interview situation. A long-playing tape ensured minimal interruptions in the conversations. Each tape was clearly labeled, and the equipment was checked to ensure proper functioning before each interview.

A closer look at some of the characteristics of each group of participants is provided in the following section.

The elimination of mechanical restraints (1928-1936). In order to obtain data regarding the general atmosphere at the hospital and the process resulting in the elimination of mechanical restraints, 15 people were interviewed. The writer was personally acquainted with 13 of the informants and had been a nursing colleague of most. Thirteen of the interviews were conducted in participants' homes; one interview was held in the general hospital and one in the researcher's home. With light conversation and the serving of refreshments, rapport was quickly established due to a comfortable, informal atmosphere. The interview questions were used as a flexible guide (see Appendix 2), and the informants were encouraged to share any additional material they considered pertinent. The open-ended interviews were generally long, leisurely, and pleasant, often taking an entire morning, afternoon, or evening. Several interviewees commented that they were surprised at how much they remembered and said they had "enjoyed talking about the old days."

Eight informants remarked that employment at the hospital had been their first employment, and all reported having come from rural backgrounds. During the time period reported on (1928-1936), all 15 interviewees held lower-level positions in the organization: ward aides, housekeeping staff, kitchen staff, and farm staff. Two of those interviewed were in their middle seventies, 12 were in their late seventies, and the eldest was 82 years of age.

The introduction of tranquilizers (1953-1957). As a means of accessing information and insight regarding the general atmosphere of the hospital before the advent of major tranquilizers and the effect of the introduction of the tranquilizers on the patients and staff, an interview guide was developed (see Appendix 3). The questions served as a guide as the writer conducted interviews with 16 former employees who had worked at the hospital throughout the period in question. Twelve had retired, and the four still employed by the hospital were nearing retirement. These latter respondents ranged in age from 62 to 70 years. The writer was personally acquainted with all of those interviewed and had worked with some over a period of nearly two decades as a staff nurse, a teacher, and/or as Director of Nursing. In contacting the prospective candidates and explaining the purpose of the study, the interviewer was encouraged to find that all eagerly agreed to participate and enthusiastically invited her into their homes. Thirteen people were interviewed in their homes, and three, due to scheduling conflicts, were interviewed in an office at the hospital. During the period under study, eight were general-duty nurses, four were head nurses, two were senior-nursing managers, one was a social worker, and one was a senior administrative assistant.

Deinstitutionalization (1967-1975). An interview guide focusing on the atmosphere at the hospital prior to deinstitutionalization of patients and the effects of the publication of the Blair report was developed and used in interviewing the 16 informants who participated in this phase of the study. Generally, these were younger than those previously interviewed, with ages ranging from 55 to 65 years. Six had retired, five were working elsewhere, and five were still in the employ of the hospital. Seven of the interviewees were head nurses, three were nursing supervisors, two were senior nursing managers, one was a social worker, and three were in support services (kitchen, laundry, and garden) during the period in question.

Ten of the interviews took place in respondents' homes, one at another psychiatric institution, one where the individual was employed, and four in an office at the hospital.

Documents and Records

Taylor and Bogdan (1984) pointed out that qualitative researchers have analyzed "organizational documents, newspaper articles, agency records, government reports, court transcripts and a host of other materials" (p. 120) in social science research. The purpose of analyzing these documents, according to Taylor and Bogdan, was to learn about the people who produce them, for "these materials lend insight into the perspectives, assumptions, concerns, and activities of those who produce them" (p. 120).

Clark (1967; cited in Guba & Lincoln, 1987) stated:

> The most important principle of historical scholarship is the principle of importance of context. When considering any historical evidence, an investigator must take account of the situation at the moment in time when the event it records happened and also at the moment when it was recorded. (p. 234)

According to Yin (1984), there are six possible sources of evidence in conducting case-study research: "documentation, archival records, interviews, direct observation, participant observation, and physical artifacts" (p. 79). The use of multiple sources of evidence is encouraged, particularly when the researcher is trying to establish a "chain of evidence" (p. 78). The first set of evidence referred to by Yin, documentation, includes the use of "news clippings and other articles appearing in the mass media" (p. 79). In the three critical events selected for this study, newspaper articles were helpful in augmenting historical detail and in clarifying positions which had been obtained from other data sources.

The Public Archives of Alberta and the Alberta Hospital Ponoka Museum provided rich depositories of materials related to the three selected critical events under review.

The Public Archives of Alberta. Government documents and records for these periods were readily available to the researcher, and their analyses supplemented and enhanced understanding of the events in question, providing deeper insight and serving as a check on the perceptions and recollections of the informants. This diverse collection of memoranda, records, documents, newspaper articles, correspondence, briefs, reports, and letters related to the selected critical events was examined for the years 1928-1936, 1953-1957, and 1967-1975. Records, documents, and newspaper articles referred to in this research are included in the reference list.

Alberta Hospital Museum. The hospital maintains a small museum which yielded historical documents and records. Other documents were discovered in other areas of the hospital. The researcher contacted many staff members who might know of less accessible records and relevant documents. Several possible locations were identified, and the researcher proceeded to search for documents in these areas. Two nursing report books for the period 1933-60 and 1933-36, for example, were located in an obscure basement room.

When other staff members were approached for additional clues, one reported that many of the nursing report books and medical order books had been sent to the hospital incinerator, and others noted that other records and documents that would have been of value for this study unfortunately had routinely been discarded or destroyed.

Data Analysis

Difficulties in dealing with voluminous amounts of data acquired through transcribed interviews, and potential problems in analyzing the data were noted by Borg and Gall (1983), Taylor and Bogdan (1984), and Field and Morse (1985). In this study the collected data fell naturally into the three areas identified as critical events and thus became somewhat more manageable.

According to Taylor and Bogdan (1984), "data analysis is an ongoing process in qualitative research" (p. 128), with data collection and data analysis occurring simultaneously.

Following each interview the researcher initiated a journal and recorded the time, date, location, and length of the interview; and the general atmosphere and response of the interviewee to the questions. The tapes were replayed as soon as possible following the interviews. Notes were made of nonverbal expressions and emerging themes; for example, "The interviewees spoke with warmth and respect in their comments about Dr. MacLean." The tapes were transcribed verbatim, with pauses in the conversation and laughter recorded.

On completion of the interviews for each of the three critical events, the researcher replayed the tapes and reviewed the transcripts. Emerging themes and interpretations were recorded, and comments in the individual journals of each interview were compared with these themes.

Copies of each interview were made so that the data could be cut (as suggested by Taylor and Bogdan, 1984, p. 138) and sorted into appropriate categories. As more information was obtained, coalescing categories were sorted into subcategories. Major themes emerged which were checked for accuracy with the initial data, collated, and incorporated into the writing of the report of each critical event. Field and Morse (1985) referred to the initial sorting of data into broad categories and, as more information is obtained, into smaller categories as "the rule of parsimony" (p. 101). An example of this occurred when data on Dr. MacLean were sorted for the first of the critical events examined in this research, the elimination of mechanical restraints. A broad category of comments on Dr. MacLean was initiated. This was subdivided into two categories related to the staff's perception of his leadership role at the hospital and his visit to Europe which influenced his thinking about the use of mechanical restraints.

Standards of Rigor

Addressing the issues of objectivity, subjectivity, reliability, and validity of the research findings, Field and Morse (1985) reported that "qualitative research has been extensively criticized for the subjective nature of the methods" (p. 115). Important factors identified by Field and Morse in evaluating qualitative research include the techniques used to select key informants, observer accuracy, observer bias, the social context under which data were gathered, the need to gather information from several sources, the history and maturation of the group, and the status of the researcher (pp. 115-118).

Guba and Lincoln (1987) stressed that the basic concerns of scientific inquiry in meeting tests of rigor apply to the naturalistic inquirer. The four terms appropriate to scientific tests of rigor, namely, "internal validity for truth value, external validity or generalizability for applicability, reliability for consistency, and objectivity for neutrality" (p. 104), are replaced with credibility, fittingness, auditability, and confirmability. Guba and Lincoln's definitions of these terms, along with the methods utilized to address these criteria of rigor, are considered in the following discussion.

Credibility

Truth value is defined as the need for the researcher to be concerned with testing the "findings and interpretations with the various sources (audiences or groups) from which the data were drawn" (Guba & Lincoln, 1987, p. 105). To meet this criterion, four members from each interview group were invited to read early drafts of the selected critical events. Each reviewer was asked to address the questions, "Does this record accurately reflect your understanding of the situation? Are there important events that have been missed?" Comments such as "This sounds like how it really was"; "Wish I had thought of some of the comments; they brought back memories"; and "You really have covered it well" were indications that the researcher had captured the experience of the informants.

Another strategy utilized to ensure the credibility of the findings was triangulation--a proposition is exposed "to possibly countervailing factors or assertions . . . with data drawn from other sources or developed using different methodologies" (Guba & Lincoln, 1987, pp. 106-107). Application of the procedure facilitated comparison of the perceptions and values presented by the respondents with the data obtained from documents and records. For example, in the third critical event examined, deinstitutionalization, the perceptions of the interviewees on the initiation of the Blair study were compared with government documents and newspaper accounts of this event.

Fittingness

Guba and Lincoln (1987) made a strong case for replacing the term generalizability with fittingness, noting that the former term cannot be "anything other than a context-free proposition" (p. 118). They suggested the use of "working hypotheses that fit more or less well into a context other than the one in which they were derived" (p. 118). The notion of thick description, which involves "the literal description of the entity being evaluated, the circumstances under which it is used, the characteristics of the people involved in it, the nature of the community in which it is located" (p. 119), provided guidance to this researcher in the conduct of this study. This is particularly evident in Chapter 5, "The Elimination of Mechanical Restraints"; Chapter 6, "The Introduction of Tranquilizers"; and Chapter 7, "Deinstitutionalization: 1967-1975," in which multiple sources of data (perceptions of the interviewees, newspaper articles, government documents, and material from Alberta Hospital Ponoka Museum) were utilized to portray as complete a picture as possible of the events under study.

Auditability

Rather than focusing on the replicability of the study, the naturalistic researcher may be more interested in the "multiple realities" of the respondents. Guba and Lincoln (1987) suggested three methods that may be used to demonstrate consistency: overlap methods (triangulation); stepwise replication (providing the information sources, documents); and the audit: "The work of one evaluator (or team) can be tested for consistency by a second evaluator or team" (p. 124).

In this study all records are available for future reference and further research; i.e., lists of interviewees, transcripts of interviews, historical documents obtained from the Public Archives and the Alberta Hospital Ponoka Museum, and local and provincial newspaper articles. Thus, another researcher examining the above data could conclude: "Yes, given that perspective and those data, I would probably have reached the same conclusion" (Guba & Lincoln, 1987, p. 124).

Confirmability

For Guba and Lincoln (1987), the issue of neutrality (objectivity) in the scientific paradigm was probably "the most thorny one that can be raised with respect to naturalistic inquiry" (p. 124). Data must be factual and confirmable whether they are gathered using quantitative or qualitative methods. Methods that establish truth value in the qualitative paradigm include "triangulation, cross-examination, persistent observation, member checks, and testing of congruence with referential adequacy materials" (p. 126).

All government documents and reports are available and can be reviewed for the accuracy of the information presented throughout this research.

Researcher Bias

Taylor and Bogdan (1984), in their discussion of research bias, noted the importance of the researcher's beginning a study "with a minimum of assumptions and presuppositions" (p. 142). "It is impossible to avoid one's own commitments and biases, however. Data are never self-explanatory. All researchers draw on their own theoretical assumptions and cultural knowledge to make sense of their data" (p. 142). The researcher was well known in the psychiatric nursing field, having worked in various capacities at the hospital for nearly 20 years: as a general-duty registered nurse, an educator, and, finally, as Director of Nursing.

The researcher had been away from the hospital for seven years when this study was conducted. A change in the hospital's organizational structure from administrative responsibility to a government department to a board structure and a complete change in the top administration at the hospital were additional factors that lent "newness" to the situation and greater objectivity to the researcher's perspective. Colleagues and interviewees who critiqued draft reports also helped to ensure the objectivity of the writer.

This chapter has addressed the issues of the research design and methodology, the utilization of documents and archival records, and the standards of rigor applied to this research.

Chapter 5

The Elimination of Mechanical Restraints: 1928-1936, Provincial Mental Hospital Ponoka

The elimination of mechanical restraints, culminating in 1936, is the central focus of this chapter. The phenomena explored in this and subsequent chapters relate to adaptive change and the development of institutional character. The role of leadership in critical decision making and in the preservation and perpetuation of values provides another focal point in the development of this chapter.

This chapter is divided into four major sections. The first section presents a perspective on the use of mechanical restraints on the international and national scenes to establish the general climate of opinion on the use of these devices. This is followed by a description of the internal environment and general treatment milieu at Alberta Hospital Ponoka. The following section presents the development of the events leading to the critical decision to eliminate mechanical restraints through key events, leading characters, major influences, and final resolution. The fourth section documents the hospital's response to the decision, the resulting changes in institutional character, and the emergence of new issues and opportunities. This chapter concludes with a brief review of the emergence and resolution of the issue of mechanical restraints.

The International and National Scene

Although more than a half century had passed since Conolly (1856), Hill (1857), and Tuke (1882) first advocated "moral treatment" and the abolition of mechanical restraints, these dehumanizing devices continued to be utilized in many psychiatric facilities well into the twentieth century. According to Deutsch (1960), one of the most discussed and least understood topics in the early organizational meetings of the American Association of Medical Superintendents of Asylums "centered around the doctrine of non-restraint" (p. 213). The American superintendents viewed the policy of nonrestraint as a "foreign" system, suitable, according to Deutsch, "for Englishmen, but it would never be tolerated by red-blooded Americans" (p. 223). The Medical Superintendents of some American institutions did, however, make serious attempts to implement the nonrestraint system, reducing the amount of mechanical coercion significantly, even "while they went about belaboring non-restraint in principle" (p. 217).

The publication in 1908 of Beers' autobiography, A Mind That Found Itself, five years after his discharge from mental hospitals, profoundly affected lay and professional people across North America. Beers had submitted his book for comments and criticism to several eminent psychiatrists, a wise decision since it prevented its dismissal as the warped notions of an ex-mental patient. Beers described his harsh and cruel treatment at the hands of attendants, including beatings, chokings, confinement to a padded cell, verbal abuse, and the application of a strait jacket for 21 nights.

Beers (1908) determined that he would experience the most violent wards in the hospital. He deliberately created a disturbance, smashing a plate-glass window with the legs of a chair. He knew that as a result of this behavior he would be secluded and placed in a strait jacket. He described his "instrument of torture" in this way:

> a camisole, or, as I prefer to stigmatize it, a strait-jacket, is really a tight fitting coat of heavy canvas, reaching from neck to waist, constructed, however, on no ordinary pattern. There is not a button on it. The sleeves are closed at the ends, and the jacket, having no opening in front, is adjusted and tightly laced behind. To the end of each blind sleeve is attached a strong cord. The cord on the right sleeve is carried to the left of the body, and the cord on the left sleeve is carried to the right of the body. Both are then drawn tightly behind, thus bringing the arms of the victim into a folded position across his chest. These cords are then securely tied. (p. 104)

While in the "Bull Pen," as he referred to the seclusion room, Beers (1908) managed to anger one of the physicians, who, described by Beers as having a Jekyll/Hyde personality, took some delight (in Beers' opinion) in personally applying the strait jacket, severely impeding Beers' blood circulation. His response to this experience is described below:

> No incidents of my life have ever impressed themselves more indelibly on my memory than those of my first night in a strait-jacket. Within one hour of the time I was placed in it I was suffering pain as intense as any I ever endured, and before the night had passed it had become almost unbearable. My right hand was so held that the tip of one of my fingers was all but cut by the nail of another, and soon knifelike pains began to shoot through my right arm as far as the shoulder. After four or five hours the excess of pain rendered me partially insensible to it. But for fifteen consecutive hours I remained in that instrument of torture; and not until the twelfth hour, about breakfast time the next morning, did an attendant so much as loosen a cord. (p. 107)

Beers (1908) was eventually discharged and recovered at the home of a friendly attendant. His experiences in mental hospitals propelled him to develop a plan of action which would result in better care and treatment of the mentally ill. As a result of his efforts, in 1909 the

Society for Mental Hygiene was established, supported by many outstanding Americans. This organization has spread worldwide and continues its advocacy role for the mentally ill to this day.

Writing about the early developments of psychiatric services in Canada, Tyhurst, Chalke, and Lawson (1963) claimed that the authorities "were concerned only with the segregation of the insane and protection of society and property" (p. 2). Canadians accepted the prevailing world views about the etiology and treatment of mental illness. Gradually, the more enlightened views of the European pioneers and their American counterparts were accepted, and some advances were made, but in Tyhurst's view, even though great advances had been made in psychiatry during the world wars, "the attitude toward mental illness remained largely administrative and legal rather than medical and therapeutic" (p. 3).

The Provincial Mental Hospital Ponoka

The rapidly growing population in Alberta during the 1920s resulted in increasing admissions to the hospital, necessitating a continuous construction program. Writing in Ponoka Panorama, a historical account of the district, Roberts (1973) described this phase of hospital development as "the construction years" (p. 197). From its beginning, a large farming operation was an integral part of the hospital. This was an attempt, largely successful, to make the institution self-sustaining. In addition, farm work was thought to be therapeutic for the patients. Slater (1973) recalled that when the hospital was opened in 1911 "there was a full dairy herd and the necessary number of horses to start farming" (p. 239). With the onset of the depression and throughout the "dirty thirties," construction of any new buildings was out of the question. However, the patient numbers continued to increase, as is illustrated in Table 4 (courtesy of Medical Records, Alberta Hospital Ponoka).

Table 4

Number of Patients at Ponoka Insane Asylum 1928-36

Year	Population	Change
1928	1,055	
1929	1,086	31
1930	1,103	17
1931	1,195	92
1932	1,271	76
1933	1,226	-45
1934	1,386	160
1935	1,490	104
1936	1,612	122
Total		557

The hospital was faced with an ever-increasing number of patients, monetary constraints, and insufficient numbers of staff. As near as can be determined, during the early and late 1920s there was a total of 95 nursing staff (Hincks & Farrar, 1929, p. 30). Many of the staff were inadequately trained, and the overcrowded facilities placed staff and patients under great stress and played a major role in defining the character of the organization.

The Atmosphere and Milieu of the Hospital

In an effort to preserve a bit of the flavor and texture of the hospital's rich history, what follows are a few recollections by those who lived through the challenges and hardships, the joys and sorrows of "the good old days," and who are, themselves, a part of that history. All those interviewed had begun work at the hospital without experience or training. Many were "fresh off the farm," and this was their first encounter with a large organization. As several noted, it was the "dirty thirties" and jobs were hard to find. Not surprisingly, a wide range of emotions was expressed as informants related their initial contact and early experiences at the hospital.

Coming from a farm to her first job, with no knowledge about or experience with mentally ill patients, Mrs. M. found the hospital "confusing," with so many duties, rules, and regulations that "you had to learn as you went along." In her view, much of the communication from the Medical Superintendent was informal rather than in written form. When the leader issued an order, it was a verbal one and was quickly passed down the hierarchy. Thus, for Mrs. M. the hospital's informal communications system, "the grapevine," was an important source of information and vital to the operation of the hospital. Mrs. M. also recalled how many patients "seemed quite normal." She said it was not until she really began to talk with them that she found their thinking was "way off base."

Several of the former staff members, male and female, made reference to the extreme overcrowding, the "maddening" noise, the lack of privacy for the patients, and the acute shortage of staff. Wards in those days housed as many as 200 patients. Staff worked 12-hour shifts with four or five staff on duty during the day and no more than two on for the night shift. Many of the residents were long-term, "chronic" patients, viewed as "lifers," who would be spending the rest of their days in hospital. These trying conditions were recalled as follows by one interviewee: "It was a scary feeling because I started on Female Four. There were about a hundred and sixty people all crowded in the dayroom with five or six staff. You were always told to keep your back to the wall in case someone would hit you. It was so crowded and noisy that you were exhausted by the end of the day."

Another informant, "fresh off the farm," Mrs. R., began as a ward aide and eventually enrolled in the four-year nursing program. Her orientation to her new role, she said, was strictly on-the-job training where "I learned as I went along." As her first day of work was a Sunday, the head nurse was not there, and Mrs. R. recalled that "the rookies just stood around watching the more experienced staff members." Mrs. R. was also shocked at the lack of privacy in the hospital. The patients were watched all the time by the staff--whether they were bathing, eating, sleeping, talking, or toileting. She recalled that "people took their baths in full view of one another and the staff. The toilets did not have any separations between them, and of course there weren't any doors." In Mrs. R.'s view, she was "cheap labor," and she remembered that on that particular Sunday a patient was knitting a shirt on circular needles. She laughed heartily as she recounted the experience of having the patient "put this thing over my head, and I really thought I'd had it."

Night duties were described as follows by another former nurse: "I was the night nurse and the night nurse's duties were to have all those patients dressed, washed, and ready for breakfast by six-thirty a.m. There were two of us and a hundred and fifty patients. You were the boss and you had to make sure that everybody was ready for breakfast on time." This "rather hectic" activity was followed by one staff member giving a report to the day staff which described the patients who were disturbed or troublesome. Patients in the seclusion rooms were fed separately by the staff, while the rest ate in the large communal dining hall.

As patients returned in single file from the dining hall, they were checked to see that their stockings were tied up with strings (made from the worn cotton sheets), that they looked tidy, and that their hair was combed. This was emphasized, as the wards would be visited each morning by the Medical Superintendent and the matron or chief attendant.

Scenes in the dining hall were described by various informants as most unpleasant and unappetizing: "It was frightening; the dining hall was so crowded. It was awful." Patients sat at long tables and were given their meals in a tin bowl, often with only a large teaspoon with which to eat. All cutlery had to be counted before and after the meal. This staff member recalled that "the place was such a mess with so many of the patients throwing their food on the floor, it was necessary to scrub the floors after each meal."

While for some staff the experience of overcrowding and shortages of staff on the wards were the most vivid and significant recollections, several staff members commented on the oppressiveness of the strict and authoritarian atmosphere. Generally, the "old-country" nurses were perceived as rigid and authoritarian: One staff member recalled:

> When I went there, the majority of the staff were from Britain or Europe. They were very strict and expected the patients and employees working under them to be obedient. I think they brought some of the traditions from their countries. I've always felt that. I don't know if I'm right.

This authoritarianism was also felt by the new staff, who perceived ward duties as focused on rigid routines with little variation from ward to ward. The new staff were well aware that they were "low man on the totem pole," as one put it. The pecking order was such, for example, that they were always the last to go for coffee and lunch. Newcomers were also expected to defer to any decisions made by the more experienced staff members.

Eleven of the staff members commented on the amount of work expected of the patients to keep the hospital running. This situation is reflected in the following comments:

> It seemed to me the hospital couldn't have run without the patients' labor. Everyone that could work did. It was supposed to be part of therapy, but that was a joke. On the male side, a staff member would appear at the door of the unit, open the door, yell "Garden gang!" and the patients would line up one by one and follow the staff member off to work. The patients would be gone for the whole day. These patients kept the grounds of the hospital looking beautiful. The patients actually had very little contact with trained staff. The head of the garden gang and his workers didn't have any training, although some were kind to the patients.
>
> Many of the women worked in what I would call the domestic services, like the kitchen, the laundry, the mending room, or the ironing room. They were a vital part of that service--food wouldn't get to the dining halls without their help. It was supposed to be therapy, but the jobs were routine, dull, and boring. If the truth were told, it was really to keep the hospital running.

Despite the overcrowding, the shortage of staff, and the strict, authoritarian atmosphere, there were experiences that were positive. One staff member recalled with pleasure one especially memorable rose among the thorns:

> Mostly, you know, people were kind and motherly. We were there to help them. I think the attitude on the ward depended on the head nurse. Mrs. O.--everyone loved working for her. She was so kind to everyone, and the patients received good care on her ward.

This head nurse was also mentioned by other informants and fondly remembered for her kindness to all, patients and staff, and for the positive atmosphere she created on her ward. She appears to have had a positive effect on the future careers of those who were privileged to work with her, and several of her staff went on to enter and complete the nursing program.

Of necessity, staff worked together closely on the wards, and one former staff member remarked that everyone had to pull together in order to survive. In addition to working together, the social life of the staff was also closely intertwined with hospital life. As one informant commented, "The staff had a great social life; they took you in, you know. They were very good to me and made me welcome." Another staff member described the hospital as being "like a small town up there" and added that "everybody sort of stayed together. When I first came, E. K. invited me to a party right away."

A document obtained at the hospital museum supports the perceptions of the staff about the general atmosphere of the hospital. Upon entering employment at the hospital, all staff were presented with a handbook, Rules and Regulations of the Provincial Mental Hospital, Ponoka, Alberta. Although the author is unknown, the year 1918 is handwritten in the upper right-hand corner. According to interviewees, this manual was in use at the hospital until the early 1950s. The document provides an indication of the prevailing atmosphere at the hospital and confirms the staff's perceptions. The Introduction focused on the purpose of the hospital: "This hospital exists primarily for the care and treatment of the mentally sick, and it is the duty of all employees to work harmoniously together to promote the general comfort and happiness of the patients."

The above mission statement is followed by sections entitled "General Regulations for Employees," "Duties of Officers," "Care of Certain Classes of Patients," and, finally, "Fire Rules." The rules for employees specify that all those newly hired were on three months' probation and "may be discharged at the discretion of the Superintendent if found wanting in the necessary qualities" (Rules and Regulations, p. 5). Hours of duty were assigned as 12-hour shifts, and each employee was given one day off each week. Refusal to obey orders would result in instant dismissal, and "wards or any part of the buildings set apart for the one sex must not be visited by anyone of the opposite sex without orders or permission" (p. 6). Order and neatness were expected in carrying out all duties, and employees could be dismissed for a variety of reasons. Some of these included "drunkenness, falsehood, disrespectful conduct towards their superior officers, ill treatment of patients, or general inefficiency" (p. 6). In addition to the many rules and regulations imposed, responsibilities of the various levels of hospital employees were spelled out in minute detail, particularly those relating to the duties of charge nurses (p. 12) and the general-duty nurses (p. 14).

The staff experienced a rigid, authoritarian, hierarchical system where orders from the Medical Superintendent were obeyed without question. Many of the staff were untrained and adopted the attitudes of those already on the job. Just as staff was expected to obey orders, so were the patients, who were considered to be on the lowest rung of the authority ladder. The overcrowding, noise on the wards, lack of privacy, poor physical facilities, and isolation from the community all contributed to the custodial orientation of the hospital staff; all were greatly influenced by the authority and clinical orientation of the Medical Superintendent.

Leadership of the Hospital

In Europe the majority of asylums were controlled by Medical Superintendents in whom great authority and power were invested. This model was transferred to North America, and the tradition was carried on by the early Medical Superintendents of Ponoka, all of whom had received their early medical education in Europe.

The following documents provide evidence of the power and authority of the Medical Superintendents. Obtained from the hospital museum, the Rules and Regulations of the Provincial Mental Hospital, Ponoka, Alberta (1918) described this key position:

> Superintendent
>
> The Superintendent is the chief executive officer and is responsible for the general efficiency and discipline of the Hospital.
>
> He shall appoint or cause to be appointed such employees as he may think suitable and necessary, and shall prescribe their duties. He shall also have power to discharge any of such employees.
>
> He shall have supervision of the buildings and grounds and of all persons engaged in the services of the Hospital.
>
> He shall make periodical inspections of the buildings, of all utilities and services in connection with the hospital and during such inspection he shall be accompanied by the officer in charge of the Department.
>
> He shall generally direct the care and treatment of the patients, and cause the medical record, clinical and statistical, of each patient to be completed and maintained from the time of admission to discharge, with the medical treatment pursued. (p. 8)

The role and power of the Medical Superintendent are further delineated in the following excerpts taken from the 1929 Hincks-Farrar report (Hincks & Farrar):

> The Superintendent is the Chief Executive Officer and is responsible for the general efficiency and discipline of the hospital. He appoints employees, prescribes their duties and has power to discharge members of the staff. He makes periodical inspections of the buildings, utilities and services and gives general directions for the care and treatment of patients. (p. 29)
>
> Standard 11. All other persons employed at the institution ought to be subordinate to the superintendent and subject to removal by him if they fail to discharge their duties properly.
>
> The Superintendent at the Ponoka Hospital has been vested with full authority in the matter of selecting and discharging subordinate officers and staff and in supervising the various departments. (p. 44)

Dr. Thomas Dawson, 1911-1916. Information on Dr. Thomas Dawson is rather sparse and sketchy. It is known that he was from Edinburgh (Roberts, 1973, p. 206) and that he believed "patients were social beings capable of benefiting from exposure to social situations" (Johnson, 1986, p. 13), but little else has been recorded as to his policies and contributions. He is given credit for initiating "the congenial relationship which has always existed between the Hospital and Community" (Roberts, p. 206) and evidently was generally viewed as a benign influence, but that is virtually the extent of the information available on Dr. Dawson's tenure as Medical Superintendent at Ponoka.

Dr. E. H. Cooke, 1916-1931. Following his graduation from Durham University, England, and a four-month training program in a county institution for mental diseases, Dr. Edleston Harvey Cooke was appointed Assistant Medical Superintendent of Ponoka in 1912. He became Medical

Superintendent in 1916 and remained at the hospital in this capacity until 1931 (Roberts, 1973, p. 206).

Dr. Cooke's authoritarian personality, as attested to by those interviewed and as reflected in his public statements, and his lengthy tenure as Medical Superintendent ensured that he exercised a major influence on the staff and, consequently, on the treatment and care of patients. Dr. Cooke subscribed to the theory of hereditary determinism, and the guiding principle of his treatment approach emphasized obedience and punishment. As he explained in an interview recorded in the June 5, 1920, edition of the Calgary Herald:

> The very ground rung of the treatment of a patient arriving at Ponoka began with obedience, without which primary attainment there could be no hope of recovery. Like a child he must be taught the fundamentals of life all over again, and like a dumb animal, to accomplish this, obedience must first be learnt. Therefore, some form of punishment must await those who persist in disobedience. This punishment in Ponoka is confinement in bed. The next principle to be ingrained into him is that of honor, which is arrived at through the same process that teaches him obedience. He is kept in bed until he promises to correct the disobedience which placed him there. He is then let out on his honor. If he breaks this he is placed in bed for a longer period, with a thorough understanding of why he is put there. They rarely have to be put to bed more than once or twice . . . before they learn that obedience will give them everything they desire. (Spectator, 1920, p. 25)

In this same paper the following week, June 12, 1920, Dr. Cooke emphasized "the five methods of treatment at Ponoka":

> Discipline; rest in bed; bathing and elimination of toxins by Epsom salts; regular habits; and last of all, but most important, the impression upon the patient when he begins to recover his mental balance the paramount importance of trying to understand himself better, by learning to know limitations and weaknesses. (Spectator, 1920, p. 12)

In an address to the Wetaskiwin Kiwanis Club on March 30, 1926, Dr. Cooke reminded his audience that the number of the "feebleminded" was increasing, and he pointed out that the government was "alarmed at the demands being made for funds to care for these unfortunate people" (p. 1). This speech, as reported by The Ponoka Herald ("Dr. Cooke") on April 8, 1926, emphasized Dr. Cooke's belief that there were "two reasons for mental disorder." The first, he stressed, was "hereditary predisposition," and the other was "great stresses or strains on the individual." In Dr. Cooke's view, approximately 75% of the cases being treated in the hospital were of the hereditary type (p. 1).

During Dr. Cooke's tenure, several buildings were constructed; the Depression, however, quickly and effectively brought to a halt construction of new buildings. During Dr. Cooke's term in office, the patient population grew from 509 in 1916 to 1,195 in 1931.

Although Dr. Cooke was successful in adopting the classification system of the American Medical Association for mental diseases, introduced the Wasserman blood test to diagnose syphilis, significantly upgraded laboratory equipment, and introduced occupational therapy as a treatment modality, his tenure as Medical Superintendent established an institutional style characterized by a rigid and authoritarian atmosphere for both patients and staff. According to Clarke (1973), Dr. Cooke established throughout the hospital "a crisp, authoritarian aura with distinct class overtones" (p. 47).

Dr. Cooke's businesslike mode of operation is clearly evident in his reports (1928-29, 1930-31) submitted annually to the government. Through the use of statistical tables, the reports record admissions, discharges, deportations, deaths, nationality, place of residence, occupation, causes of attack of insanity, and forms of mental disorders. Tight, concise sentences note changes in medical staff and the

Superintendent of Nurses. Special mention is made of new buildings for patients and residences constructed for doctors.

Dr. Cooke's reports (1928-29, 1930-31) are noteworthy for their focus on statistical tables including the "Table Showing Movement of Patients During 1928; Showing the Civil State of Patients Admitted; Showing the Nationality of Those Admitted; Place of Residence at Time of Committal; Showing Statistics of Heredity; Alleged Causes of the Attack of Insanity in Those Admitted." One gets the impression that the writer of these reports was someone with a scientific orientation and a strong adherence to efficiency in the organization. Only once, in fact, did he leave a record of a remark about a particular patient:

> On September 12th, a male patient was fatally injured by an attendant who was subsequently tried, and found guilty of manslaughter and sentenced to five years penal servitude. Arising out of this incident, a detailed survey of the mental institutions in the province was made by Drs. C. M. Hincks and C. B. Farrar, who submitted a full report and recommendations. (Cooke, 1928-29, p. 41)

Dr. Cooke did not indicate in this report or any subsequent documents whether or not any of the recommendations by Hincks and Farrar were acknowledged or implemented.

Dr. Cooke was called upon to cope with the unremitting overcrowding at the hospital and was primarily responsible for overseeing a continuous program of expansion. There was a high turnover of staff, and those available lacked training in the care of mental patients. The latter part of Dr. Cooke's tenure was characterized by a series of crises. The deaths of two patients, the subsequent publicity, and the letters received by the government from patients alleging mistreatment were indications of the seriousness of the problems at the hospital under Dr. Cooke's tenure, no doubt contributing to his resignation in 1931.

The autocratic power invested in the Medical Superintendent ensured that the institution became his "lengthened shadow" and could not but reflect the character, personality, and beliefs of the incumbent in the treatment of the mentally ill.

Dr. Charles Baragar, 1931-32 and 1935-36. Dr. Cooke resigned in 1931 and was replaced by Dr. Charles Baragar for one year (1931-32), after which Baragar became Commissioner of Mental Institutions and Director of Mental Health for the Province of Alberta. Due to the economic constraints brought about by the Depression, this position was abolished in 1935, and Dr. Baragar was re-appointed to the position of Medical Superintendent at Ponoka and held the position from 1935 to 1936. Although Dr. Baragar's time at Ponoka was short, he was instrumental in establishing, along with the matron of the time, Miss Catherine Lynch, a four-year course in nursing at the hospital. As noted in an unpublished biography of Dr. Baragar by Dr. Randall MacLean (1963), Dr. Baragar "embarked immediately upon a vigorous campaign for improvements in all facets of Mental Health of the Province. He was determined particularly to improve the care and treatment of the mentally ill" (p. 4).

In Dr. Baragar's (1931) first submission to the provincial government, there was a distinct change in the style and substance of his annual reports from earlier reports written by Dr. Cooke. The statistical tables remain, but more attention is focused on "Clinical Work and Reorganization: Hydrotherapy, Occupational Therapy, Social Service, Training School and Recreation and Entertainment" (pp. 85-86).

While Dr. Cooke's tenure created strong militaristic trends at the hospital, Dr. Baragar appears to have made a deliberate effort to shift the focus to providing a more therapeutic environment for patients and toward improving the expertise and morale of the nursing staff.

Dr. George Alexander Davidson, 1932-1935. In the interim between Dr. Baragar's appointments as Medical Superintendent, he was replaced by Dr. Alexander Davidson from 1932 to 1935. Davidson carried on the projects initiated by his predecessor, and, upon his resignation in 1935, he returned to private practice in Vancouver.

Dr. Davidson's annual report of 1933 continued the tradition and style set by Dr. Baragar, noting the addition of a patient's library (p. 73), the organization of a Dramatic Society and Glee Club (p. 74), "a series of very enjoyable staff dances" (p. 75) and, concluding the report, he emphasized, "Outstanding events are the graduating of the first classes of nurses and attendants" (p. 77).

Dr. Randall Roberts MacLean, 1936-1948. Having arrived at the hospital in 1928 as a junior medical officer, Dr. MacLean assumed the position of Medical Superintendent in 1936. Dr. MacLean's annual report of 1936 indicated that he was a courageous leader in that, for the first time in the hospital's history, one of its chief officials publicly acknowledged problems within. Dr. MacLean noted, for example, that "the influenza epidemic which swept through the institution, especially the male side, was particularly hard on the elderly patients, and many survived but a few days after the onset of the illness" (p. 71-72).

Dr. MacLean's (1936) concern with patient welfare was clearly evident. His report stated:

> Great concern is felt for the safety of a large number of defenseless patients on the overcrowded wards. In some instances there is scarcely enough room for the patients to sit about comfortably, and when moving about there is great liability to being pushed or attacked as a result of coming into physical contact with others. (p. 72)

Dr. MacLean further emphasized the difficult conditions at Ponoka in the following excerpt from the conclusions of his annual report noted above:

> Overcrowding has increased and again dominates the picture. All services are taxed to their utmost, and the situation has become not only serious, but very grave. The health and safety of the patients and staff are at stake, and additional accommodation should, and must, be provided if admissions are to continue. Much of the progress made in recent years will be lost if some relief is not given to the overcrowding in the very near future. (p. 79)

Many of those interviewed called attention to the concentrated power of the medical staff, particularly that of the Medical Superintendent, in the functioning of the hospital. Comments from several interviewees reflected this observation:

> Boy, when the doctor said something, everyone hopped to it!
>
> They nearly had me fired; one of the doctors thought I didn't show enough respect.
>
> The Medical Superintendent in those days ran the whole show; whatever he said went. All the doctors had a lot of power, but we got to know them as people. The only time you saw the Medical Superintendent was when they made rounds. If you were called to his office, you knew it wasn't good news.

The organization of the hospital reflected the power of the elite group, the medical doctors, particularly the Medical Superintendent. His beliefs about the etiology and treatment of the mentally ill were reflected in staff interactions and attitudes toward the patients. In this hierarchical system, shaped as a pyramid, the Medical Superintendent was clearly at the top, the staff was in the middle, and the patient was on the lowest rung.

Thus, the organization of the asylums strongly reflected the beliefs of the Medical Superintendent in the treatment of mental illness. As the early superintendents at Ponoka had received their initial training in the British Isles, it is therefore not surprising that the institution at Ponoka strongly reflected the views of its British leaders.

Treatments and Procedures

Following the initial general questions about the atmosphere and milieu at the hospital, respondents were asked to reflect on the treatments and procedures for patients that were in place during this period of 1928 to 1936. The informants described the treatment and procedures utilized in the hospital, particularly the use of mechanical restraints. Additional information which served to clarify the data from the interviewees was obtained from nursing report books and medical order books.

The respondents were not given a definition of mechanical restraints, and the responses to the questions reflected their beliefs as to treatments available and their subjective feelings about the use of such measures. For all respondents, the most familiar device was the camisole or strait jacket. Sedative packs and continuous baths were also mentioned. Three of those interviewed noted the use of seclusion rooms in combination with strait jackets, sedative packs, and continuous baths.

One former staff member, Mr. Y., responded to a question about the use of mechanical restraints as follows: "My general impression of the treatment was the lack of it--the lack of organized treatment programs.

On admission and on what we called the convalescent wards there was a routine more or less geared toward safety." This routine included the continuous bath, in which the patient was placed in a hammock in a bathtub or put in a sedative pack. In the latter, the patient was wrapped in wet sheets in such a manner as to prevent any movement and would frequently go to sleep. In Mr. Y.'s opinion, both of these procedures comprised a form of mechanical restraint.

Another retired staff member described the use of the "heat box" in her narrative:

> The treatment in those days when I came here was mostly sedative packs, continuous baths, and I don't know what you call it--it was a heat box you put them in. It had doors on it, a light bulb inside. It really made them perspire. All there was was their head looking out.

This staff member recalled that the use of the heat box was discontinued in the early thirties shortly after she had begun working at the hospital.

The use of the strait jacket or camisole as a type of restraint was described in detail, and very animatedly, by Mr. M.:

> There were strait jackets, and they were made of a kind of ticking. They were made with cloth sleeves and opened down the back. They tied in the back, and when you put them on, you crossed their arms in front and tied the strings behind them. It didn't contain them. Some were too big, and some weren't big enough.
>
> Also, there were sedative packs. They put two gray blankets on a bed and then they wet a draw sheet and a normal sheet, put the normal sheet on the bed, and then the draw sheet was on top. This draw sheet was brought up and under their arms like this and underneath the same on both sides; then the sheet was wrapped around, and it was wrapped between the legs and brought out under the bare leg like this, and the other one was wrapped over the two legs so their skin didn't touch, and they were warm.

According to Mr. M., the patients were then wrapped in two gray blankets and strapped to the bed, whereupon they would perspire profusely and frequently would fall asleep.

When questioned about specific patients "treated" with mechanical restraints and as to why the devices were used, Mr. M. recalled:

> A little boy who was famous for his rambunctious behavior, his name was H.F.--you no doubt heard of him--and there was an older gentleman, an English fellow. He was very, very intelligent, but he was a depressive, and he felt sorry for little H.F. He bit the patients and he bit the staff, so he was in a strait jacket much of the time, and the older fellow [Mr. L.] used to get permission to take him out for walks. He had him, of course, trussed up in this thing, and he had him on a leash. I was always afraid H.F. would get away from him and he would rush up and bite the first person he saw, whether it was a child or anyone on the grounds. I don't remember that ever happening, although there were lots and lots of staff who had bite marks.

Another informant recalled an ex-soldier who was subjected to continuous restraint:

> I remember C.M.; he was an ex-soldier from the First World War. He was into restraints all the time. He would eat his own feces, you know, and that's why he was kept in restraints. You couldn't keep him away from the bathroom at all. He was in there all the time, and that's why they kept him in restraints.

In addition to their mentioning particular patients, all of those interviewed noted that restraint was generally used with highly disturbed people; e.g., "manics and people who were impulsive or suicidal." More specifically, one interviewee insisted that "only the ones who would hurt somebody would have restraints." According to another, "You would need to use restraint when the patient was determined to clean somebody's clock. Cleaning their clock meant somebody got pretty badly mauled."

Further supporting this "last resort" view, another interviewee stated, "Restraints were used on highly disturbed people, manics, and some schizophrenics, when they were excited." He added that the restraints did help to quieten people, and, with a few exceptions, the patients would not be in continuous restraint, but it was restricted to when they were disturbed. For some people, this might occur about once a month.

Seven of those interviewed stressed that the strait jackets were used on very few patients, and only with those who were most seriously disturbed. In speaking about a specific ward, one commented, "There were about a hundred and fifty on that ward, and four would be in strait jackets." As another indicated, "It depended on the ward. On Male Ten there might be a couple. On the Geriatric and Infirmary wards, there was a different type of restraint used." This informant, Mr. Y., described how the back legs of the chairs would be cut off, forcing the chair to tilt back. When placed in this chair with a sheet tied around his middle, the geriatric patient would be unable to fall or get up from the chair and wander about.

Eight of those interviewed focused their attention on those who had been in strait jackets or subjected to hydrotherapy and sedative packs which were utilized during that period. Four of those interviewed made particular mention of the use of restraints at night, such as tying patients in bed, secluding them, or using medication, usually paraldehyde or barbiturates.

The following recollections support the staff view on one ward, in particular, that patients infrequently were placed in strait jackets, but two interviewees recalled that often patients were tied down at night. This procedure was not perceived by the staff as restraint. According to Mr. S.:

> On that ward there would be six or seven out of a hundred and fifty, but then there were also some tied down at night. I can visualize G.S., who made a lot of noise and abused himself so badly that they would tie him down at night. Then there was another patient [J.J.]: every week she tried to commit suicide, so she would be tied down.

Mrs. G. also recalled that there were some "very rambunctious patients who needed to be secluded every night in order for them to settle down." In thinking about the nightly seclusion of patients, she mentioned that some just went to the door automatically, and they were locked in. She added that this routine often took place without staff thinking about whether or not a given patient really needed to be secluded; and many patients evidently had come to accept automatic seclusion as their lot in life.

The Decision to Prescribe Restraints

When asked who made the decision to use mechanical restraints, the majority of those interviewed responded that it was the doctor who had made the decision, and many stressed that one had to get the doctor's permission to make use of restraining devices. The authorization for the procedure was explained with statements such as "The doctor would make the decision--you had to phone and get permission," or "The medical staff would. You had to phone and say, 'So-and-so can't be controlled,'" or "It was always a doctor's order, but I think it was the nursing staff who decided. The nurse would really make the decision, and the doctor wrote the order."

While agreeing that a doctor's order was necessary before mechanical restraints could be used, Mr. S. illustrated the point that, in actuality, the decision was made by nurses: "It was the doctor's order for hydrotherapy, continuous bath, and it was supposed to be the doctor's decision to restrain a patient, but I think some of the doctors were, you know, lazy." Mr. S. pointed out that once the doctor and staff member "got to know each other," the staff member would restrain the patient as was considered necessary, with the doctor signing the order "after the fact."

Two of those interviewed mentioned the use of "standing orders," which further supports the notion that, while officially only the doctor could order the use of mechanical restraint, in practice it was the nurse who made the decision. Standing orders would be written by the doctor when he visited the ward during the day and would remain in effect perhaps for months, until cancelled by the doctor.

The following comments reflect the view that the official policy regarding the use of restraints was interpreted loosely in everyday practice. While emphasizing that it was the doctor who ordered that the patient be restrained, Mrs. E. observed:

> The charge nurse actually had the responsibility of deciding because she was really the one who knew her patients. Sooner than waiting for someone to get hurt, she usually knew well enough what was coming. It was never, to my knowledge, used as a form of punishment; it was used as a form of protection.

The above view was further supported by another staff member, who added:

> I think there was a general order for patients that they could be restrained, and then it would be up to the head nurse or whoever was in charge to use that order. The doctor would write the order, and the nurse would make the decision as to when it was necessary.

The information obtained from the respondents was supplemented by documents obtained from the hospital museum. They included the large nursing report books the size of business ledgers which were utilized on each ward to alert the Medical Superintendent, the matron, or chief attendant to any significant happenings on the ward. Entries were made twice daily, at the end of each day and night shift. They were then taken to the office of the matron or chief attendant. From there, each morning they were passed on to the Medical Superintendent. These lines of communication were maintained until the late 1960s. Regrettably, for purposes of this study, many such documents from the period 1928-36 are missing. Two books were found, however, that shed a substantial amount of light on the period in question. One reported on male patients for the year 1929, and the other pertained to female patients in the year 1928. On the male ward the patient count varied between 64 and 74. Records covering three months were reviewed. They revealed that an average of five to seven patients per month were subjected to continuous baths or sedative packs, and three patients were in restraint, generally for one to three days. The figures for the female ward followed the same pattern with regard to the use of restraint.

The female ward had 114 to 122 patients by daily count. On this unit 12 to 14 patients were usually identified and documented as having been subject to some form of restraint as earlier defined. Seven of these were reported as having received continuous baths, and two were otherwise restrained. Staff on the female ward was generally more consistent than that on the male ward in reporting reasons for the use of restraint. Descriptions such as "troublesome," "tearing sheets," "resistive to feeding," "pulling out hair," and "very excited" and/or "excitable" were common characterizations of patients' behaviors.

The available nursing report books support the staff contention that mechanical restraint was used on relatively few patients, and significantly less frequently on some wards. It is of interest to note that a particular patient's name often appeared with regularity, generally on a monthly basis, as having been placed in restraint. Also, for a few patients it was accepted by both patients and staff that they would be placed in restraint routinely, rather than as a specific therapeutic intervention prescribed on the basis of troublesome behavior or difficult circumstances. This would appear to represent the "old guard" clinging to outmoded therapeutic strategies in the face of change.

The staff Rules and Regulations booklet provided some guidance to staff about the use of mechanical restraint. The "Care of Certain Classes of Patients" is specifically outlined; included were suicidal, violent, homicidal, delusional, destructive, helpless, sick, epileptic, and general paralytic patients (pp. 18-21). Of particular interest to this investigation is the subsection dealing with the care of the violent patient. Nurses were instructed "always to keep calm and collected" (p. 18) and to maintain a "friendly bearing" (p. 18) in the care and control of violent patients. In addition, "those who have not sufficient good nature and self-command to meet even serious provocations without losing their temper are unfit to be nurses" (p. 18). These same nurses are exhorted "unfailingly to exercise kindness, forbearance and good judgment" (p. 18). The instructions become even more specific and insistent in the following rules designed to protect patients from physical abuse by staff:

> It is absolutely forbidden:
> a) To slap or strike a patient.
> b) To trip or throw down.
> c) To twist the arms or wrist or hold by the hair.
> d) To place the weight of the body or knees upon chest or abdomen.
> e) To choke or place anything over the mouth that interferes with breathing. (p. 19)

Finally, the issue pertaining to the use of mechanical restraints is specifically referred to in a subsection of "Care of Certain Classes of Patients":

> No punishment (for instance, cold spray, purgatives, deprivation of food or clothing) for any offense whatever will be allowed and no mechanical restraint of any kind shall be used without the express permission of the Physician. Seclusion, that is, the locking up of a patient against his or her will, must be done only under the direction of a Physician. (p. 18)

Although the use of mechanical restraints was a fact of everyday life at the hospital on many of the wards, why the issue was not addressed as a separate heading in the Rules and Regulations booklet referred to earlier remains open to question. Perhaps in the face of pressure to eliminate the use of mechanical restraints, management simply chose to call a minimum of attention in hopes of defusing the issue.

As noted above, evidently very few patients were subjected to the use of mechanical restraint, although the definition of mechanical restraint varied for each interviewee. For some, it was clearly delineated as the strait jacket, while for others it included the use of seclusion, continuous baths, or sedative packs. Officially, it was necessary to obtain a doctor's order to restrain a patient, but in actual practice the nurses on the ward, particularly the head nurses, made the decision to restrain a patient.

The hospital at Ponoka displayed many of the characteristics of a "total institution" (Goffman, 1961). Staff and patients could spend long periods of time away from the community. The institution was, for all intents and purposes, self-sustaining. It was only a matter of time before cracks appeared in the hierarchical, authoritarian, repressive atmosphere. The death of a patient in 1928 at the hands of an attendant and the subsequent events which led to the decision to abolish mechanical restraints form the next part of this chapter.

The Decision to Abolish Mechanical Restraints

In the early 1930s severe underfunding for the institution, partly as a result of the country's economic depression, combined with an ever-increasing hospital admission rate and the small numbers of available staff, created severe financial and social pressures within the hospital. At the apex of the hospital hierarchy was the Medical Superintendent, who made all decisions pertaining to hospital life. Staff roles were clearly delineated; cleanliness, orderliness, and efficiency were highly valued; and a general air of authoritarianism pervaded the internal social environment.

Emergence of the Issue

The death of Dr. Arthur Hobbs, a prominent veterinary surgeon, while he was a patient at the hospital was the first public indication of problems at Ponoka. He was a former resident of Medicine Hat and an ex-member of the Royal North West Mounted Police. The circumstances surrounding Dr. Hobbs' death were discussed at the Medicine Hat branch of the Canadian Legion. A motion was passed requesting "a thorough and complete investigation into the matter and into the management of the Ponoka Mental Hospital so that those responsible for this brutal treatment shall be adequately punished and a repetition of such treatment to other inmates should be properly guarded against" ("Ponoka Asylum," 1928, p. 1).

The death of Dr. Hobbs sparked a series of articles in The Edmonton Journal, and on September 17, 1928, the headlines read, "Patient Dead; Eight Arrests Ponoka Asylum." An attendant was alleged to have assaulted the patient, and this led to the arrest of the accused attendant on a charge of manslaughter. The arrest of seven others took place as a result of "charges of assaulting and causing grievous bodily harm" (p. 1) to another attendant who had reported the incident. Throughout 1928 the Ponoka Hospital continued to make news, and on October 24, 1928, The Edmonton Journal reported, "Ponoka Attendant Is Given 5 Years" (p. 1).

The local newspaper, The Ponoka Herald, demonstrated keen interest in reporting the success of the hospital's football team, bazaars, and dances and generally focused on the social activities at the hospital. A rare exception to this more positive slant appeared in the September 20, 1928, edition ("Ponoka Hospital Attendant"), wherein it reported the incident involving a patient's death, a hospital attendant having been charged with manslaughter, and seven other attendants sentenced to two months' hard labor (p. 1). In contrast to news reports in The Edmonton Journal, The Ponoka Herald placed primary emphasis on the patient. The writer stated that the patient had been at the hospital "for some time" and went on to say that he "was continually under the delusion that some person was trying to poison him, and as a result the authorities usually experienced some difficulty in getting him to take his meals" (p. 1). The article went on to describe how the patient had "declined his food" and how "the attendant lost his temper and began beating the patient" (p. 1).

Several patients managed to "smuggle out" letters to government officials. As all of the patients' mail was censored, it must have been with some difficulty that this was accomplished. A female patient explained in detail her confinement at the hospital and gave several examples of brutal treatment by nurses (Letter, Patient to Brownlee, October 20, 1928). She did receive a response from the Premier, who stated that her letter was under review by the Minister of Health, George Hoadley. Brownlee's written comment on the letter provides valuable insight into the prevailing attitude of government officials:

> From my reading of her letter I think you will have to be careful that she does not become a "woman with a mission" and cause your department considerable embarrassment in the future in her zeal to improve conditions at Ponoka.

With the death of the patient and subsequent trial of the attendant, public pressure was put on Premier Brownlee and his Minister of Health to address problems at Ponoka. The Premier and his cabinet visited the hospital, and, it was reported, they "came away with the impression that the capacity of the institution is taxed almost to the limit and that something must be done shortly in the way of providing relief" ("Ponoka Institution," 1928, p. 1). The report went on to say that the Premier "paid a warm tribute to the superintendent, assistant superintendent, and medical staff" and that he had been highly gratified at the general air of cleanliness and efficiency in evidence at the Ponoka Hospital (p. 1).

The 1928 report of the Board of Visitors for Public Institutions, a group of five representative people from the community empowered to inspect all confinement institutions and provincial hospitals, is of interest. The board supported the view that "the Mental Hospital at Ponoka is efficiently and economically administered. Further, . . . no complaints were preferred by any of the patients, thus reflecting favorably upon the treatment received" (MacEachran, 1928, p. 9). These reports supported the administration of the hospital; they did not address such issues as the use of mechanical restraints with patients. A search of the Provincial Archives of Alberta, the Legislative Library, the University of Alberta Archives, the Edmonton City Archives, and Records Management, Alberta Health, failed to produce records of Visiting Board Reports for the years 1928-36. Evidence that the Visiting Board, which also functioned as the Eugenics Board, continued to exist and visit the hospital can be found in the following comments in Dr. Davidson's annual report of 1933: "The Eugenics Board of the Province was invited by the Minister of Health to act as a special inspecting board" (p. 75).

In response to media pressure and growing public concern, the government set up a commission to conduct an inquiry "into the present administration and management not only of the Ponoka institution, but also of the institutions at Oliver and Red Deer" (Hoadley, October 5, 1928). Accepting the request of the government to conduct this investigation were two prominent Ontario psychiatrists, Dr. C. M. Hincks and Dr. C. B. Farrar. Dr. Hincks was for many years Medical Director of the Canadian National Committee for Mental Hygiene. It was his suggestion that Dr. Farrar, a colleague, become part of this team. The investigators were to address six basic issues:

> the methods of conduct, management and administration; evidence showing that any patients . . . are subjected . . . to ill or improper treatment; . . . having regard to the best standards existing in similar institutions; the sufficiency of the existing buildings, equipment or staff; recommendations for the care and treatment of neurotic patients; and the making of recommendations arising out of the foregoing which may seem proper. (Hoadley, October 5, 1928)

Conducted during 1928, the investigation utilized the 19 asylum standards developed by the Canadian National Committee for Mental Hygiene to assess mental-health services in the province. With 38 of the 59 pages of the report focused on Ponoka, it is clear that the main purpose of this exercise was to probe the Ponoka hospital. Considering each standard in turn, Hincks and Farrar (1929) assessed the ability of the hospital to meet these standards. The majority of the points of commendation focused on the grounds, the physical plant, and the cleanliness and well-nourished look of the patients. Major concerns identified by the investigators related to the treatment of patients, overcrowding, staff attitudes, lack of staff training, and excessive use of seclusion and restraint.

Of particular interest are the investigators' comments on the use of restraint. They noted that 24 patients were placed in restraint during the day, 15 female and 9 male. During the night nine female and eight male patients were in restraint. The most common reasons given included "restlessness," "danger of injury to others," "danger of self-injury," "tearing of clothes," and "destruction of property" (Hincks & Farrar, 1929, p. 34). The writers quoted the work of Tuke (1882) of

England and Pinel (1792) of Paris, who were viewed as having demonstrated that restraint was unnecessary in the treatment of mental patients.

In the opinion of the Commissioners, "This method of control is used to excess and in forms that are unduly severe" (Hincks & Farrar, 1929, p. 35). Mention was made of the four cage beds, the strapping of patients, and the use of camisoles. The authors of the report emphasized that if the orientation of the mental hospital was the promotion of the recovery of patients rather than staff convenience, it would have little use for restraint or seclusion. Indeed, the authors emphasized that the use of restraint or seclusion would "aggravate symptoms and jeopardize recovery" (p. 36).

Hincks and Farrar (1929) went on to point out that with a patient population of 1,051, it was impossible to separate the more severely disturbed cases from those well along in their recovery. In addition, overcrowding was said to make it impossible to provide separate facilities for the sick and infirm, even for those with tuberculosis. The report also noted that the 95 nursing and attendant staff were inadequate both in numbers and in training to care for the 1,051 patients (p. 30).

Included in the many recommendations of the Hincks-Farrar Report were the initiation of a training school for the male and female nursing staff, the reduction of restraint and seclusion, the development of "a more humanitarian attitude to the patient population," "the decrease of overcrowding and the utilization of hydrotherapy and occupational therapy" (Hincks & Farrar, 1929, p. 75).

The Hincks-Farrar Report was tabled in the Legislature on February 6, 1929. In the ensuing discussion of the report in the legislature, after reviewing recommendations for changes, the opposition asked for the resignation of the Minister of Health. The countercharge of the Minister, as it later appeared in headline form, was that "Hoadley Claims Charges Are Only Made for Political Purposes" (1929, p. 1). The Premier, in turn, refused to ask for the Minister's resignation. The response of the government to pressure arising from recommendations of the Hincks-Farrar Report was (1) to move 60 patients from Ponoka to Oliver ("Greater," 1929, p. 17; "Relieving," 1929, p. 1); (2) to construct more staff cottages (in 1929); and (3) to open two male (in 1930) and two female (in 1931) wards. These steps and further allocation of funds for the development of the Oliver institution located outside Edmonton were reported in The Edmonton Journal as they came to light in 1929.

The Ponoka Herald, however, neglected to report on the critical discussion that was provoked in the legislature following the tabling of the Hincks-Farrar Report. Prior to the tabling of the report in the legislature and subsequent discussion, The Ponoka Herald ("Report") had published a summary of the findings in the February 14, 1929, issue. It focused on recommendations for changes as set forth in the report, particularly noting, "Forcible feeding of patients at Ponoka is carried out to excess," and "Mechanical restraint of patients by the use of strait jackets, cage beds and the like is also practiced to excess" (p. 1).

The report of the death of another patient, James Walsh ("Searching," 1929, p. 1), "at the hands of a fellow inmate," was another indication of the seriousness of the problems at Ponoka.

As recorded by The Ponoka Herald on May 22, 1930 ("Premier Brownlee Nominated"), Premier Brownlee received the unanimous nomination of the United Farmers of Alberta (U.F.A.) convention and defended the need to construct more public buildings, stressing that "the number of insane persons in the province increases each year by 100" (p. 1).

A notable exception to the usual focus of The Ponoka Herald on the hospital's sports and social events appeared in the newspaper upon the resignation of Dr. Cooke. On August 20, 1931 ("Dr. E. H. Cooke"), the newspaper noted that the superintendent "was always ready to take part in the welfare of the staff and his severance from the institution will be missed, and the best of wishes will go with the doctor and his good lady" (p. 1). The appointment of Dr. George A. Davidson as the new Assistant Medical Superintendent was duly noted in The Ponoka Herald on October 1, 1931 ("New," p. 1).

The year 1932 was characterized by a general lull in news about the hospital, and 1933's most newsworthy recorded event was the graduation of 8 nurses and 23 attendants in a ceremony chaired by the Minister of Health. In his remarks, the Minister, the Hon. George Hoadley, congratulated the graduating class and also took advantage of the occasion to express how "highly pleased" he was "with the manner in which the institution is being conducted in all its various branches" ("Graduation," 1933, p. 1).

The death in 1934 of yet another patient admitted to the hospital only four hours previously gave rise to the following headline in the

March 5, 1934, edition of The Edmonton Journal: "Man's Bruised Body Brought to Edmonton as Brother Complains" (p. 1). The inquest and subsequent hearing, including the questioning of those involved, were reported in great detail in the newspaper. The jury in this case found the patient had died of "acute heart failure" and that the attendants had provided "all care possible" ("Ponoka Staff," 1934, p. 1).

The Ponoka Herald continued to concentrate on social events at the hospital, with special attention given to the graduation exercises. The patient's death in 1934 was reported in the Ponoka paper ("Ponoka Hospital Patient's," 1934), with emphasis on the coroner's jury ruling that the attendants "should be exonerated" (p. 1).

The appointment of the new Minister of Health, Dr. W. W. Cross, noted in The Edmonton Journal, September 28, 1935 ("Silent," p. 1), provided an interesting insight into the thinking of the government regarding mental health. Dr. Cross, portrayed as a "silent, country lover," made headlines with his treatise on "Aims to Empty Asylums." In the article he stated that he hoped to "implement a system started in England whereby a psychiatrist visits each school every year, picks out the weak children, and gives them special training." In Dr. Cross's view, "This can possibly save them from becoming possible wards of the state" (Section 2, p. 1).

That there were substantial problems at Ponoka during the latter part of Cooke's tenure (1928-31) is undeniable. The death of Dr. Hobbs was the first indication of the seriousness of the situation at Ponoka. Public concern pressured the government to take steps toward correcting the problems at Ponoka. The Hincks-Farrar commission addressed the deficiencies at this institution through the utilization of nationally accepted standards. In contrast with the perceptions of the staff, Dr. Hincks and Dr. Farrar found many areas requiring immediate attention, particularly the use of restraint, which they reported was being used to excess. This was in direct contrast to the recollections of former staff members who reported that restraint had been used minimally at the hospital around the time of the Hincks-Farrar Report.

Resolution of the Mechanical Restraints Issue

Once information had been obtained regarding how the mechanical restraints issue had emerged and how it had been addressed by the various influential groups, interviewees focused on the decision-making process through which the problem was ultimately resolved.

Although none of the staff interviewed had participated in the decision to abolish mechanical restraints, all were affected by it. As became clear through the interviews, from the beginning of his tenure at the hospital Dr. Randall MacLean had been opposed to the use of mechanical restraint. The warmth of Dr. MacLean's personality and the staff's perception of his role and status appeared to have had a major impact on how the eventual decision was received by staff. While some resistance was evident, the status of the doctor, as well as the necessity for keeping one's job during the "dirty thirties," effectively precluded any open, organized opposition.

As one staff member, Mrs. O., described the situation, "The atmosphere around the place was such that when the doctor said this is the way it is going to be, the staff went along with it." The doctor, although off the ward most of the time, was perceived as being in charge, with his orders carried out by the head nurse. Rounds were conducted every day, with the Medical Superintendent and/or the matron or chief attendant visiting each ward. This daily visit was seen by the staff as an "inspection" by which the general cleanliness of the patients and ward were ensured.

As a young physician (1931), Dr. MacLean had traveled abroad and taken post-graduate study in Boston, London, and Zurich. He returned to the hospital with fresh ideas, one of which evolved into the decision to eliminate mechanical restraints at the hospital. As one staff member remembered:

> Randall went overseas, and when he came back he said all the restraints were to be abolished. We were a bit appalled at that, but he also said we could put them in seclusion, and that worked reasonably well. The only thing that didn't work was if anybody had a sore that was bandaged, they wouldn't leave it on. They would tear it off, and it was just hopeless.

This impression was shared by 10 of the former staff interviewed. As one put it:

> I believe Dr. MacLean went to Europe, and when he came back he said no force should be used. And Dr. MacLean discontinued everything except sedative packs. And I remember he emphasized there was to be no force; he emphasized it very strongly that patients were not to be abused in any way, physically or emotionally.

The forceful personality of Dr. MacLean and his positive relationships with staff had a major influence on how the decision was received by staff. One interviewee noted that "Dr. MacLean was absolutely superb with the patients, and I don't think he was very particularly happy after he was taken off the wards to become administrator." Another provided further insight into the powerful influence of MacLean's presence:

> I would think it was his personality. Everyone liked him. I think he was studying in Europe and probably brought back ideas with him. If he said to do something, it would be done. The hierarchical system ensured that once Dr. MacLean had spoken, it would be done.

Expressing some anxiety that had been felt by many in regard to the change in policy regarding restraint, another staff member said, "I thought we would get killed." Others also remember that at about the same time, more educational opportunities were becoming available. As one put it, "I think that was the first time I got clinical teaching on the wards." Concurrently with Dr. MacLean's having come back from studying in Europe with new ideas and the will to implement them, more educational opportunities were being made available for staff. New graduate nursing staff, largely registered nurses, were hired. These staff members were given head-nurse positions soon after their arrival, replacing the former staff who had been in charge of the wards. Many of the older staff were untrained or had been given no more than a "short course" in psychiatry. As Mrs. M. recalled:

> The newer staff were trained. Most of the other staff who were in charge of a ward when I first went there left when they lost their positions, or they went some place else. Some of them moved over to housekeeping. You can understand their feelings. They carried the load for so long, and all of a sudden these twenty-one-year-old graduates were coming along and taking over for them, which was kind of sad, but most of them adjusted very well to it.

The role and response of the doctors is illustrated in the following recollection: "I remember Dr. MacLean. He was so opposed to any kind of restraint, and we all knew that. We really liked him and tried to avoid using it because it really upset him. If he ever saw anybody that was kind of bound or restrained, he would raise Cain: 'Get him out of that!'" This informant went on to say that when this doctor most dedicated to change retired, "restraints seemed to creep back in again."

It was also necessary for the patients to adjust to changing attitudes and actions on the part of the staff. As one informant put it, "The patients were so institutionalized, as they had been hospitalized for so many years. It had been a routine for them for so many years, a change was hard on them, and it takes adjustment."

Several former staff members spoke of the surprise and relief they had felt that "the patients were better when they took them out of restraint jackets." In addition, others responded that the patients "wouldn't do a thing. Some people got into the habit of putting them in restraints, and they wouldn't try them out of restraint."

As one staff member poignantly expressed her concern:

> It's my impression that when people were put into mental institutions, as they were called then, I think they just got over the "asylum" bit by the time I went there. Whoever put them in--parents, brothers, sisters--forgot about them and never came near them and that was the big tragedy, I think.

Another informant, Mr. M., vaguely recalled "some hearings" but thought that they had no noticeable effect on policy or procedures at the hospital. He noted that "the hearings did not make the papers." He went on to say, "When a patient got hurt and there was an investigation, it did not make the papers." He said he believed that the decision to stop using mechanical restraints came from the staff at the hospital, particularly the doctors and nurses, those "who were trying to do better." As another former staff member reported, "The public wanted them [the patients] segregated, and I don't think they [the public] cared." This individual emphasized that she was unaware of any pressure from the community to improve treatment for patients.

In ascertaining the part played by community pressure in influencing the decision to abolish mechanical restraints, the interviewees were asked questions related to community response to the use of restraints. The opinions expressed by those interviewed supported the observation that the hospital was not viewed as a part of the local community. It was in many respects an island community, and when patients were admitted into this insular world they also became isolated, if not alienated, from the wider community.

Both the isolation of the hospital and the feelings of the staff concerning the lack of involvement of community members are clearly illustrated in the following vignette from one interview:

> I remember going to a girl's funeral. We were the only two at the funeral home and a young girl came in. I would imagine this patient would be around forty, and this young girl came in, and she was dressed in these gaudy clothes. I noticed her because people usually dress a little subdued at a funeral. She had just come down from Carstairs. She said she never knew she had a sister until her family had been notified that she died. In those days when they'd have funerals and nobody would go, they'd always send staff--two staff, a male and a female. That was my experience; it sure left a bad impression.

While several interviewees reported having been unaware of any outside pressure to change treatment at the hospital, examination of available documents, as noted earlier, reveals that such pressures had, in fact, been exerted from time to time. This lack of awareness on the part of those interviewed may be a reflection of their status at the time they were on the wards, as none held a position of leadership. Thus, the pressure to change was probably directed to the head-nurse level or higher and was seen by those interviewed as coming from the head nurse or the physicians.

Nine of the interviewees emphasized that the pressure for change came from within and was led by the medical staff, particularly Dr. MacLean. In the view of one respondent, "The stigma of mental illness was evident in the many people who passed their relations off to Ponoka and shut them out of their minds." Most of those interviewed expressed strong feelings about the community that, as one put it, "shunned the place as much as possible." The effect that this factor had on patient care is deserving of more than a passing acknowledgement, but these concerns are beyond the scope of the current study.

The role of the Medical Superintendent and the visiting boards is clarified in the following recollection: "I don't remember any outside pressure. I recall pressure from the head nurses because they were in charge. There were visiting boards that came around periodically, and they wrote reports on what was happening." Dr. Randall MacLean was seen by nine interviewees as the prime mover in the eventual decision to stop using mechanical restraints at the hospital. It is interesting to note that Dr. MacLean was remembered as the Medical Superintendent, although he was not appointed to this position officially until 1936 after having served in several other capacities in the hospital. Certainly, from the staff's recollections, he emerges as the leader who was most influential in improving the care and treatment of the patients and was primarily responsible for putting a stop to the hospital's use of mechanical restraints.

Response of the Staff

While many of the staff supported the decision to stop using mechanical restraints, pockets of resistance were evident throughout the hospital. Although the resistors never became organized to any great extent, resistance evidently loomed large in the minds of many who worked on the wards at the time. Resistance to the change would appear to have been most characteristic of "the older staff who came from the old country," as one informant put it. Another felt such resistance was evident "more in the way they expressed themselves, maybe in the attitude suggesting it won't work." They evidently believed, "If it ain't broke, don't fix it!" as one put it. In any event, the resistors apparently never became either well enough organized or sufficiently bold to risk voicing their dissenting view to the hospital administration.

The respondent quoted above was somewhat more specific in expressing her view that "there were some very tough Scottish and English nurses. Some of them had a bit of training, but none of them would be graduate nurses." These "tough nurses" were seen as the core of the resistance to change in the utilization of mechanical restraints.

Two individuals in particular were mentioned as the primary holdouts:

> There was Miss M. and M.Y. They were very convinced that we couldn't do more than what we were already doing. Of course, they didn't get too much of a chance to argue about it, because they were demoted once we got registered nurses who took over the wards.

There was evidently a general reluctance on the part of those opposed to the change to voice their concerns, as, according to several informants, "they were worried about losing their jobs." As it turned out in the case of several, their concern was entirely justified. In assessing the response to the change, it is important to recognize that as the decision to do away with mechanical restraints was introduced and implemented, the trend toward hiring staff with more education was already well underway, and more educational opportunities were being made available to staff within the hospital. At the same time, however, "there was more seclusion and more baths and sedative packs." Restraint, when deemed necessary, increasingly was prescribed and administered in other forms.

The change was said to have been a "gradual process," and most of the staff members were agreeable to it because they were genuinely concerned with helping the patients. Five interviewees remembered that the change evolved over a period of four or five years. As one particularly insightful respondent expressed it, "People had to use their personalities rather than just ordering patients about."

This subtle yet dramatic shift in attitude gradually came to be accepted by many of the staff. As one staff member summed up the changes in attitudes and policy in regard to mechanical restraints, "There wouldn't be an order; it just evolved--a very slow process."

Summary

This part of the study has focused on the period from 1928 through 1936, within which the decision to abolish mechanical restraints was implemented. Overcrowding and staff shortages were everyday facts of life at the institution. It was not unusual during that time to have the day room, a centralized gathering place on the ward, crowded with as many as 150 patients and with no more than four or five staff to look after them. The majority of the staff was untrained, and the budget at the hospital scarcely covered the bare essentials. It was a time of struggle and strain for patients and staff alike and called for extraordinary coping measures to make the best of extraordinarily difficult circumstances. Yet, despite these difficulties, a strong leader, Dr. Randall MacLean, met the challenge through his role as medical officer and superintendent and pressed forward with determination to change things for the better. Although there was some resistance, the staff generally supported his efforts.

Dr. MacLean did not become the official leader, the Medical Superintendent, until 1936. His leadership qualities and the esteem in which he was held by the staff resulted not only in the elimination of mechanical restraints, but also in dramatically changing the custodial, militaristic, and rigidly authoritarian atmosphere at the hospital into a more humanistic, therapeutic environment which quickly became more beneficial and enhancing for patients and staff. His influence on the staff was noted and reported with great respect and fondness by many of those interviewed.

The hospital at Ponoka had inherited and carried on traditional beliefs and attitudes of the time with regard to the treatment of the mentally ill, but change was in the wind. While some of the staff worked resolutely toward assuring more humane treatment, others can only be described as having remained restrictive, rigid, and punitive. Fortunately for all who followed, the more enlightened attitudes and approach of the former eventually prevailed.

Despite the best efforts of some well-motivated staff, severe overcrowding, staff shortages, and lack of staff training created formidable obstacles to achievement of a more humane and genuinely therapeutic institution. Life in the organization for the residents reflected these problems. Routines were established which facilitated the handling of large numbers of people and resulted in a dehumanizing environment for staff and residents. It was the introduction of the tranquilizers, discussed in the next chapter, which permitted the movement towards a more therapeutic environment.

Chapter 6

The Introduction of Tranquilizers: 1953-1957, Provincial Mental Hospital Ponoka

The period from 1953 through 1957 marked a turning point in the history of the Provincial Mental Hospital at Ponoka, one that was shared by psychiatric institutions around the world. This pivotal event was the introduction of tranquilizing drugs, which amounted to a significant change in the treatment of mental illness, and the second of the three major critical events that were examined in this study.

This chapter begins with a review of the treatment of mental patients nationally and internationally (circa 1953) and a short history of the introduction of the tranquilizers to North America. This overview is followed by a description of the hospital prior to the introduction of the tranquilizers. A third section presents the key events that led to the introduction of the tranquilizers and the staff's and patients' response. The changes in hospital practice and organizational culture resulting from the critical decision to introduce the tranquilizers are then examined; and the chapter concludes with a review of key events, the role of the leader in introducing this change, and the resulting changes in institutional character.

The National and International Scene

In their review of developments in psychiatry over three decades, Kaplan and Sadock (1985) noted that "by the mid-1950's increasing attention was being paid to the social situations of mental institutions, first in England by Maxwell Jones in *The Therapeutic*

Community (1953) and then in this country by Stanton and Schwartz in The Mental Hospital (1954)" (p. 2053). While the publication of these books stimulated self-examination of the social milieu by the staff of some mental hospitals, it was the initiation of chemotherapy that, according to Kaplan and Sadock, "had the effect of triggering a major turning point in psychiatry, to the extent that scores of patients were released from mental hospitals, and many other patients were, as a result, not even admitted" (p. 2054).

The work of Jones (1953) promoted the idea that the total experience of the patient in hospital should be thought of as treatment. In this author's view,

> Treatment to be effective will not only involve the handling of the individual's neurotic problem, but also an awareness of the fresh problems which the fact of being in a neurosis hospital will create for the patient, and what aspects of the social situation can be used to aid treatment. The patient, the social milieu in which he lives and works, and the hospital community of which he becomes temporarily a member are all important and interact on each other. (p. 53)

In the therapeutic community program initiated by Jones (1953), daily discussion groups were held in which free speech and emotional responses were emphasized. Patients participated in decisions affecting their own lives, as well as in work programs and psychodrama sessions. An attempt was made "to build up a therapeutic community where each member of the staff has a clear concept of his or her role" (p. 151). Communications received special attention "throughout the entire Unit population, together with free discussion of any problem affecting the community" (p. 158). The aim of this novel treatment was "to achieve a communal responsibility in relation to all our Unit problems whether they relate to patients or staff" (p. 159). Jones recognized that redistribution of responsibility frequently increased tensions on the unit; yet, in his view, it led "to a far more realistic attitude towards treatment" (p. 159). Jones' work in England received world-wide attention and recognition. Examination of the social milieu in mental hospitals suddenly was very much in vogue, and in some institutions attempts were made to humanize conditions for patients and staff.

The social relations on a disturbed ward of a mental hospital, in which the researchers had noted a situation of low morale between female nurses and patients, were investigated by Schwartz and Will (1953). Low morale was defined as "a process of ineffective participation with patients" (p. 338). The investigators focused on the interactions between a particular nurse and her patients "to elaborate the nature of the processes involved in the development of low morale" (p. 338). In interviews with the researchers, the nurse indicated that she was experiencing a sense of failure, anger, and resentment toward her patients and the hospital which was leading to feelings of discouragement and indifference. This was accompanied by a change in her perception of patients, and she began to focus on the negative aspects of the patients' condition and to feel strained if not overwhelmed. She responded to her feelings of isolation by physical and emotional withdrawal from the ward. As the nurse withdrew from interacting with the patients, patient-initiated interaction with the nurse also decreased. Interventions with the nurse consisted of discussions in which the nurse was encouraged to express her feelings in a noncritical environment. The nurse was encouraged in her attempts to develop an attitude of inquiry toward herself and other people on the ward. As the nurse gradually became a participant-observer of her own reactions, she developed increasing insight into the processes of her own low morale. The impression of these investigators was that as the nurse's morale improved, there as an improvement in the morale of the patients on the ward. The practical implications of this research were that, in this particular case of low morale, discussions with the nurse of her day-to-day interactions led to the development of her understanding of the ramifications of her activities and an increase in the morale on a particular unit.

A three-year socio-psychiatric study of a ward in a mental hospital by Stanton and Schwartz (1954) is one further example of the focus during the fifties on the importance of the environment in the treatment of patients. These authors defined the function of the mental hospital as not unlike that of any organization: "It is a highly organized arrangement whereby human beings can live together and meet each other's and their own needs in a relatively predictable way" (p. 28).

Stanton and Schwartz (1954) paid particular attention to organization, both formal and informal, in the hospital and especially on the wards. The roles of the doctor, nurse, and aide; the role of the patient; communication of information in the organization; and the decision-making and enforcing-of-decisions processes were all brought under scrutiny. Staff disagreements and the effect they had on the social milieu, for both staff and patients, were examined. This research emphasized the need to explore the attitudes of those working in mental hospitals and the relationship between social interactions and mental functioning. More specifically, it addressed the need for the patients to be active participants in their own treatment rather than acting as passive recipients of therapeutic interventions.

A significant finding of Stanton and Schwartz's (1954) research was that when the highly developed and complicated organization worked smoothly, "morale of the personnel was high and usually patients tended to improve; it is possible but unproved that many smoothly working parts of the organization, like the reputation of certain patients, may have functioned to keep the patients stably ill" (p. 404). But improvement of patients was usual during periods of effective collaboration on the part of the personnel, and, in some way, the factor of organization itself seemed important in the general therapeutic effects of the hospital in bringing about the "spontaneous" improvements which occurred.

Stanton and Schwartz (1954) acknowledged that the hospital was "conspicuously successful in protecting the public and in meeting the minimal needs of patients" (p. 402). It was found to be less successful "in meeting the more highly cultivated needs of patients and in bringing about lasting improvement in mental disorder" (p. 402).

Stanton and Schwartz (1954) suggested that the principles of administration appropriate to running a factory are not appropriate for a mental hospital and that it must be realized "that mental illness and its treatment require a setting and a framework different from that of any other institution, and may require a different apparatus" (p. 405). In the view of Stanton and Schwartz, freedom was not only the absence of restraint, but, rather, freedom was to be found in a situation where consensus in decision making was present between the physician, the nurse, and the patient. This type of freedom "is a special type of organization of interpersonal relations, and is not the absence of restraint or discipline" (p. 407). The researchers observed the general ferment and skepticism of the staff in mental hospitals. They found increasing acceptance of the idea that "the mental hospital is a social system and that the meaning of any action taken within it can be known only if the context is known" (p. 408). In the move away from the belief that patients are not merely passive recipients of treatment but also active participants, "many hoary cliches become obviously ridiculous and wider vistas are opened for imaginative planning of hospital care than a generation could exhaust" (p. 408).

The study by Stanton and Schwartz (1954) chronicled the complexity of interpersonal relationships among staff and patients in a mental hospital. The effects of these relationships on the patient, both good and bad, were clearly documented. These researchers were successful in identifying the problems inherent in the traditional administrative organization of the mental hospital and its contribution to low employee morale and inadequate treatment of patients. The hospital was deficient in so many ways that the researchers concluded: "The present mental hospital is largely a historical accident; it has not been planned systematically on the basis of current knowledge of the nature of mental disorder" (p. 404). These serious defects included a high turnover of personnel, frequent placement of the care of patients in the hands of beginning nurses and physicians, inadequate decision making, and the resultant problems in locating, diagnosing, and correcting difficulties. Conspicuously absent from this study was any reference to the newly introduced tranquilizing drugs.

A study by Greenblatt, York, and Brown (1955) of two mental hospitals in the United States provided insight into the psychodynamics of the functioning of mental hospitals and their effects on patients and staff. The study documented the therapeutic strategies developed to move these organizations from a rigid custodial orientation to a more flexible and more holistic approach fostering greater staff sensitivity to the needs of the patients.

Starting with the premise that "the basic function of hospitals for the mentally ill is the same as the basic function of general hospitals" (Greenblatt et al., 1955, p. 3), the authors proposed the hypothesis that the function of a mental hospital should include

> the utilization of every form of treatment available for restoring patients to health or helping them improve sufficiently to be able to leave the hospital at the earliest possible moment; and, short of such success, it is aiding them to live as nearly normal lives as possible within the institutional setting. (p. 3)

In Greenblatt et al.'s study every aspect of the hospital environment was examined, from the policy for admission of patients to postdischarge follow-up plans. The admission of patients was described by Greenblatt et al. as "a classic example of man's insensitivity to man, under the guise of psychiatric treatment" (p. 45). Patients were admitted through a large iron gate and up a back staircase, and they were forced to take a bath where every piece of personal identification was removed, including the patients' clothes, eyeglasses, dentures, and rings.

This initial dehumanizing experience on admission was modified through a series of policy changes which not only sensitized the staff to the patients' experience, but also included the addition of comfortable furniture, attractive pictures, and drapes. As a result of these changes in both policy and staff attitudes, patients were no longer hurried through the admission procedure and were given a choice as to whether they preferred a bath at that time or later.

In the two hospitals participating in Greenblatt et al.'s (1955) research, efforts were made to eliminate what they called the "major evil" (p. 55) of the seclusion of patients. During a psychodrama session with patients and staff, the "underlying punitive meanings" (p. 58) that most patients and personnel attached to seclusion were clarified.

Three factors that contributed to the reduction of seclusion were identified by Greenblatt et al. (1955). The first was the belief that seclusion could be reduced by supporting the ward staff through the implementation of a new, more humanizing policy on seclusion; the second focused on the inclusion of all ward personnel in the planning of the treatment program for patients; and the third factor assured that all patients "removed from seclusion" would be involved in "major rehabilitation" (p. 75). This rehabilitative program included group activities, physical exercise, occupational therapy, and various recreational and sports activities.

Noting the abuse of sedative drugs in the management of psychotic patients, Greenblatt et al. (1955, p. 18) briefly referred to two new drugs, chlorpromazine hydrochloride (thorazine) and serpasil, as having "a favourable influence on some states of anxiety, tension, and excitement" (p. 82). While stressing the newness of information about these drugs, the authors, nevertheless, saw them as being "in a different class from barbiturates" (p. 82) and "a promising addition to the therapeutic armamentarium in psychiatry" (p. 82).

Greenblatt et al. (1955) saw the future of psychiatric hospitals as

> hopeful--more hopeful than would have been believed possible two decades ago. With prompt and intensive treatment provided through the somatic therapies including chemotherapy, individual and group psychotherapy, and the therapeutic use of

> the social environment, a large proportion of patients admitted to psychiatric hospitals can return to the community within a relatively brief period. (Greenblatt et al., 1955, p. 424)

With their focus on the social milieu of the hospital, the interactions of people, and the effects of these social influences upon patient care, these studies cited are examples of the types of investigations that proliferated in the fifties, studies that grew into a movement to examine the institutional character, mission, and organizational functioning of mental hospitals.

Belknap (1956) conducted an exploratory case study of the social organization of a state mental hospital. In this particular setting, a strong informal organization of the wards was maintained by a core group of 18% of the attendants. The core group of attendants was able to define the expected behaviors of their fellow workers with regard to their interactions with patients and their superiors. Belknap found that "most of the treatment of the patients in the wards we studied was dictated by the status they came to occupy in the organization of patient status under the attendants in the ward" (p. 170).

Rather than abandoning the state mental hospital, Belknap (1956) suggested two primary changes. The first would involve redefining the hospital's function through the removal from the state hospital of "the welfare and mental deficiency problems in the local communities" (p. 214). The reduction in the size of the hospital population was a critical step to ensure the success of the second suggested change, which would involve the redesign of the administrative organization of the hospital from an authoritarian line-and-staff-command organization to a system of linked services with medical supervision.

A motivating force in Caudill's (1958) study of a small psychiatric hospital was the need to develop an understanding "of the broad context of the therapeutic process in a psychiatric hospital" (p. 3). The hospital was considered a small society, an organization, in which "a complex system of human interaction takes place within which the performance of technical tasks takes place" (p. 3). The main conclusion of this study was "that a psychiatric hospital is indeed a social system, and that the properties of such a system constitute a set of significant variables which affect the quality of behavior in all areas of hospital life" (p. 318).

Caudill (1958) noted that the psychiatric hospital had retained many of the organizational features of a general hospital. In his opinion, many of the problems found in the psychiatric hospital may be found in any hierarchically structured organization. The answer, according to Caudill, is not to circumvent these hierarchical structures or to do away with the organization entirely, but to devise a better organization. He supported his argument by commenting on administrative procedures and therapeutic techniques which have been introduced to combat the apathy and inertia found in many mental hospitals. These programs often fail because they are usually added on to the overall programs at the hospital, rather than administrators considering "shifts in the functions of the doctor, the nurse, and the patient" (p. 340).

The high turnover of personnel related to lack of job satisfaction was a major concern of Caudill's (1958) study. He recognized that the nurses provided continuity of care and suggested that "one possible way out of this might be the open delegation of greater responsibility and commensurate power to the junior medical staff and nursing personnel"

(p. 343). Recognizing the gross anomalies and inadequacies of large mental institutions, Caudill nevertheless promoted the idea that "a certain amount of friendly human contact between patients, and between patients and staff, is necessary before clinical use can be made of a more sophisticated understanding of group dynamics" (p. 343).

North Americans were first alerted to the potential of the new tranquilizing drug chlorpromazine through a report by Lehman and Hanrahan (1954) on their work with 71 psychiatric patients over a four-month period. Appearing in the Archives of Neurology and Psychiatry, this article described their experience with a new drug which "seems to possess specific properties for the management of excited states" (p. 227). Chlorpromazine was utilized in this research as a sedative for two groups of patients: those who were "severely agitated" and those in "states of moderate restlessness" (p. 229). The side effects of the drug include a significant drop in blood pressure, some tachycardia, pallor, motor retardation, unsteady gait, wooden facial expressions, some Parkinsonian-like symptoms, and lethargy. These effects were seen to be of "minor significance" (p. 235) when compared to the therapeutic effects on the patients. As observed by these researchers, "The patients who present management problems become tractable" (p. 230); and although the patient "presents the aspect of a heavily drugged person, one is surprised at the absence of clouding of consciousness, impairment of judgment, or disinhibition of affect" (p. 231).

On initiation of this drug, some positive results are usually observed within a 24-hour period, and "the patient soon becomes cooperative to nursing care" (Lehman & Hanrahan, 1954, p. 232). The authors concluded their findings with the statement that the drug "has proved to be of unique value in the symptomatic control of most types of severe psychomotor excitement" (p. 236).

This report, which has become a classic and is frequently referred to in the history of the development of antipsychotic drugs, sparked tremendous interest and hope throughout psychiatric circles in North America.

Azima (1955-56) summarized the findings of an international conference held in Paris entitled "Chlorpromazine and Neuroleptic Medications in Psychiatric Treatment." The majority of the 112 papers focused on chlorpromazine, and several of the speakers provided especially interesting observations. Schneider, for instance, observed that "this drug over periods of two years or more may prevent chronicity," while Racamier believed that it would prevent "the deterioration concomitant with prolonged hospitalization" (p. 749). Many of the presenters commented on the anxiety-reducing effect of chlorpromazine, while Lehman and Hanrahan (1954) extolled its "selective inhibition" (p. 750).

The conference concluded that

> chlorpromazine and reserpine were not curative agents; they had no causal influence; that they were symptomatic medications which could arrest the evolution of acute psychoses; that they might open the way for other therapies, particularly psychotherapy; that they should not be considered as "psychiatric aspirins." (p. 750)

In the 1950s social scientific studies of mental hospitals brought to the attention of the public and professionals the debilitating effects of the large warehouses which housed the mentally ill. Attempts were made by some leaders of these institutions to change the institutional character from a custodial to a more humanizing therapeutic orientation. The publication of scientific studies and the introduction of the tranquilizers brought hope to all those involved in the treatment of the mentally ill. In the following section, documents and interviews with staff present a picture of the hospital as it was perceived prior to the introduction of the tranquilizers.

Provincial Mental Hospital - Pretranquilizers

Writing in Ponoka Panorama, a history of the area, Earl Roberts (1973), a longtime staff member, called attention to several changes at the Ponoka Hospital during the fifties. There was "a return to more construction, after a fairly long drought" (p. 201). The number of patients in hospital continued to climb, reaching an all-time high in 1953 of 1,589. Some relief to the severe overcrowding and lack of therapeutic facilities was provided when in 1950 a new occupational therapy building opened, followed by two men's dormitories, Eastview in 1952 and Dawnview in 1954. Each of these wards housed 100 men who, with staff supervision, supplied labor for the farm and grounds, as well as for the dietary and laundry services. The women contributed to the overall functioning of the hospital through their work in the dining halls, laundry, main kitchen, and ironing room.

Staff recalled this pretranquilizer period as a time when the hospital was beginning to change: "There were a lot of studies coming out about the harmful effects of mental hospitals on the patient, and we started to look at ourselves and what we were doing to patients."

Remnants of the overcrowded custodial era remained, however. Mrs. J. provided this insightful recollection:

> In the public's and staff's opinion, the patients were seen as underprivileged people, so there was very little privacy; the patients were dressed in ward dresses and had no say in their treatment. One of the things that is still clear in my mind are these tea boxes where all the patients' shoes would be placed at night. Needless to say, this led to considerable confusion in the morning when two of us had to dress a hundred and twenty-five patients. We always ended up with two mismatched shoes; the poor last patients!

Mr. X. reminisced about the ward associations: "We had ward associations on several wards, on the male and female side. This was, I believe, an attempt to give the patients some say in their treatment and in the running of the ward. It seems to me it came out of Maxwell Jones' work" (referred to earlier). In the view of Mrs. R., the success of the ward associations very much depended "on whether the staff were willing to give the patients a say in the running of the ward. Some staff were pleased and encouraged their development, while others just tolerated or ignored it or pretended they were giving the patients a say."

Although many patients were discharged during this time, (e.g., 506 in 1953), the patient count remained high due to the number of admissions--684 in 1953. This situation at the hospital is reflected in Table 5, based on data provided by Clinical Records, Alberta Hospital Ponoka.

The severe overcrowding, in the view of Mr. A., resulted in "a continual hubbub." He went on:

> There was absolutely no quiet area. Everybody was in the one dayroom; it was side by side all the way around, and half the middle was filled with people, too. People were just packed in. There was just no privacy whatsoever. You can imagine a hundred and thirty people in one dayroom. It was unreal. Needless to say, there would be lots of fights, and we were constantly breaking them up.

Table 5

Total Number of Patients, 1953-1957

Year	No. of patients	Change
1953	1,589	No change
1954	1,543	-46
1955	1,589	+42
1956	1,521	-64
1957	1,523	+ 2
Total		-66

Mr. J. looked back on this time as

> spending my whole day doing things. You were really busy cleaning the patients, cleaning the ward; you had to polish the floor with huge blocks. You really didn't have much time to spend with patients. Cleanliness was seen as next to godliness, and there were frequent inspections by Dr. Michie [Medical Superintendent] and Miss Kemp [Superintendent of Nurses].

Mrs. C., now an 80-year-old lady who worked at the hospital for 32 years, recalled the following incident:

> I remember Miss K. [the Superintendent of Nurses] coming on duty one weekend on Female Six. We didn't have enough staff to take anybody out of the seclusion rooms, and so we'd call down to see if we could get some staff to help us. Miss K. said she would try and get somebody, and if not, she would come over herself. She ended up coming on the unit and working the whole shift.
>
> This one patient, Annie L., needed a bath. Boy, was she tough! We were all scared of her. We all took our glasses off; she would break them, rip our caps, our watches, pins, everything. Miss K. came in, completely dressed, and told Annie she was going to have a bath and not to rip her gown. Annie just got in the tub, splashed around a bit, and Miss K. took her out of the tub and put her gown on. Annie never touched her. Annie clearly knew who the boss was and respected Miss K.

Mrs. J. remembered:

> Before the tranquilizers, many of the patients had their teeth pulled out because they were biters who bit staff or each other. Due to the fact that ninety percent of the patients on the east end didn't have teeth, suppers consisted of a pureed main course sort of like a gruel, gravy in it, and it smelled. These patients ate a lot of bread, and, of course, there were no oranges or apples and certainly no salads.

Describing what the hospital was like before the advent of tranquilizers, Mr. H. reflected on his first assignment at the hospital:

> It was Male Ten, and there were about a hundred patients and, at the most, five or six staff. Many of the patients, about half, were "low functioning" and suffered from senile dementia. Some had organic illnesses like syphilis. I remember it very clearly. I was handed a scoop shovel, a barn broom, and a bottle of Ajax and taken down to side rooms to clean them. That was a morning's work right there. The finger painting was real, as high up as the guy could reach. The day was spent changing clothes, taking care of the people strictly on a custodial basis.

Another staff member, Mr. L., remembered all the patients having to get up at 6:30 a.m.:

> We shaved them with a straight razor. We would line them up and go from one to the other, using the same blade. The bathing, too, was pretty crude. It was duck, rinse, and dry, and, needless to say, the bath water was used for several patients. The beds were about six inches apart, and it took me about two days before I realized that the fellow who looked after making the beds was not a staff member, but a patient.

Mr. B., coming to the hospital in early 1953, was assigned living space in a room above one of the units. "Believe me, it was noisy," he stated and went on to recall that, because of the large number of patients, many of the day rooms were covered with mattresses during the night:

> They were piled in a corner during the day. On some of the wards, seclusion was the big thing. The wards were so crowded that if one person became upset, the whole unit got going. The only thing to do was to isolate that one person as quickly as possible so you could keep some sort of control.

In Mrs. R.'s view, there were two groups of patients:

> There were those who were quiet, sat in a corner, and didn't cause any trouble. We didn't have time to be bothered with them. Then there were the ones who took up all of our time. They were very active, starting fights, moving all over the place, and just generally getting into all kinds of trouble. Unfortunately, they got all the attention.

A staff member, Mr. S., remembered coming onto a unit for the first time:

> One of the interesting things there, you could come onto a ward perhaps on afternoons; you'd never even been on that ward, much less knew any of the patients. "Here's the med keys, have a good evening, good-bye": That was your orientation. If you were lucky, the head nurse might tell you, "Check with that patient; he knows all the patients on the ward." I can remember going on Male, and the head nurse handed me the med keys and said, "Don't forget: Get out your four o'clock meds before supper. H.M. and Bill [two patients] will help you with any problems."

Some of the "therapies" utilized in the hospital brought back a flood of memories to the respondents. Ten of those interviewed commented on what they saw as the "overly generous" use of electro-shock therapy on the patients, and their feelings about the procedure are fairly well summed up in the comments of Mrs. S.: "A large amount of ECT was given. It was all unmodified, and after nine or ten ECTs many of the patients were incontinent and their heads completely scrambled." Mrs. S. continued:

> I felt really sorry for these patients. They were petrified, and we had to drag them down to the treatment room. I always hated to come to work on Tuesdays and Thursdays--those were the ECT days on our ward. That was a horrible way to treat a person. It seems to me some of the staff would get the doctor to order ECT as a punishment for the patient.

Staff generally reminisced about the use of insulin coma therapy with mixed fear and fondness. As recollected by Mr. R.:

> Insulin coma therapy was used on a small group of patients--10 or 11, I believe--throughout the fifties. The hospital was still separated, male and female side, and there we had a male

> and female nurse as co-group leaders, and the mix of male and female patients. After the patients had recovered from their comas, then we had a group therapy session. Everything was covered. It was really whatever the patients wanted to talk about. When I first started in the group in 1953, no one really knew a lot about group therapy process.

Four of the staff recalled difficulties in patients' recovering from insulin coma. According to Mrs. A:

> There were some patients who seemed to take a very long time to recover. These were frightening times for me. I don't think we ever lost a patient. Really, I think that's why the Sunnyside group was started in 1964--to see if we could get the same results with group therapy without using insulin.

One staff member, Mrs. S., remembered her first tentative attempts at group therapy with delight and humor:

> I had just graduated from the hospital, and Miss K. decided that I would be responsible for four or five female patients with leucotomies [this type of surgery, prefrontal lobotomy, severed the fibers connecting the frontal lobe with the hypothalamus]. Well, we had to start right back at square one: Patients didn't know their names, they were incontinent, and their affect was flat. One day this patient really didn't seem to be paying any attention in group. I sent her a note asking her if she would tell the group her name. Well, I received the note back with "Go to hell" scribbled across the top. She laughed as she recalled that the patient was more with it than she had realized!

Mrs. M. reminded the interviewer that "we used a lot of paraldehyde mixed with chocolate syrup. In my opinion there wasn't anything that could cover the taste of paraldehyde." Other staff members recalled giving phenobarbital to the "epileptics," while others remembered the large amounts of castor oil and epsom salts routinely given to patients. "I think it was to get rid of the devil or whatever," said Mrs. M.

The early 1950s were a time of expansion both in the number of buildings and in the increased numbers of patients. Despite these difficult circumstances, some attempt was being made to develop treatment programs. Electro-convulsive therapy and insulin coma were common treatments. Group therapy was tentatively being introduced into the hospital. The custodial design of the hospital buildings and the continuing overcrowded conditions for patients and staff are well documented in the annual reports of the Board of Visitors.

The Visiting Board, chaired by university professor Dr. J. M. MacEachran, continued its yearly visits to the hospital. The annual reports of 1954 and 1955 expressed great concern with the severe overcrowding at the hospital. The government was urged to increase the bed capacity of the provincial institutions, as is illustrated in the following comments:

> It is most gratifying to know that, since 1948, 1579 beds have been added to these institutions and that 786 additional beds are to be provided during 1955-56. Still further, 1000 more will be provided with the completion of the new Deerhome at Red Deer, in the, we hope, not too distant future. The problem of over-crowding which has been the most difficult and most persistent problem of all Mental Hospitals in Canada is, it is safe to say, well on the way to a reasonable and early solution in Alberta.
>
> As to (2), very substantial progress has been made in all the institutions and, according to present plans, is certain to continue. In the Mental Hospital, Ponoka, however, certain difficult problems remain. These are due, in the main, to the sound, yet, from a modern point of view, faulty structure of the older original buildings. They have to do mainly with the lack of suitable unified accommodation for the administrative offices and up-to-date facilities for the Reception Services. Kitchen and bakery, so important in an institution of this size, have long been under criticism, and their extension and remodeling is at present made impossible by the location of the Power Plant. (MacEachran, 1954, p. 2)

The Visiting Board report (AHP Museum) of 1955 to the Honorable W. W. Cross, Minister of Health, commended the Director of the Division of Mental Health for

> the effort that is being made to overcome one of the most persistent problems confronting the Mental Institutions in Canada and the United States. This is the problem of over-crowding, which in this Province, is aggravated by the rapid

> increase in population and the 15 to 20 percent increase in the number of older patients admitted to these institutions. (MacEachran, 1955, p. 1)
>
> In summing up the meeting at the Provincial Mental Hospital, Ponoka, the various Board members expressed pleasure over the improvements which had been made since the last visit, and paid tribute to the staff for their unceasing efforts to make the best of existing facilities. The Board expressed the opinion that progress was being made each year, and mentioned especially that it was obvious that all staff members here worked with a view to giving the best possible care and treatment to the patients--from the Medical Superintendent to the Nursing Staffs and all the ancillary staffs, including the farm staff. (MacEachran, 1955, p. 13)

Several comments contained in the report of the Visiting Board for 1956 could be seen as attempts to pressure the government into addressing the problems of overcrowding outlined in its annual reports of 1953, 1954, and 1955.

The Visiting Board, in reviewing the duties of the Board members, emphasized their responsibility as representatives of the public to report "on the quality and efficiency of the care and treatment of the patients" (MacEachran, 1956, p. 2) in government institutions. It is clear that the Board members took their mandate seriously. Following this review, the Board reminded the government that its activities were carried out quietly, without attracting public notice or giving the press notices of its meetings. The absence of any newspaper reports, interviews, or public addresses to explain the members' activities or findings is justified as

> a precaution against the possibility of such findings becoming, without full knowledge or proper understanding of their context and setting, objects of political controversy which might be unfair to the Institutions and detrimental to the confidence reposed in them by the public. (p. 2)

Following this reminder to the government of the Board's mandate and its discreet method of functioning, the report returned to the problem of overcrowding in mental hospitals, which had been addressed in previous reports and observed that "the most difficult problem with which the Mental Hospitals in Canada and elsewhere have had to contend, it is safe to say, has been that of overcrowding" (MacEachran, 1956, p. 3).

While giving the government some credit for its efforts to remedy these conditions and to "improve the therapeutic function of the Mental Hospitals" (MacEachran, 1956, p. 3), frustration on the part of the Board members was evident in the following:

> In every report of the Board, special attention has been called to the overcrowded condition of the wards of the Mental Hospitals and its effects in making treatment very difficult and in some cases next to impossible. For the Board, whose duty was to represent the public, those conditions were, to say the least, very disturbing and painful. For the medical staff and other officers of the Hospital, they were most frustrating and disheartening. (p. 3)

The problem of overcrowding at Ponoka was given special emphasis. There, it was pointed out, "the congestion has been particularly acute" (MacEachran, 1956, p. 4). The main buildings were said to be designed for custodial care, having been

> built with thick brick and stone outside walls and partitions and were three to four stories in height. They were badly lighted and badly ventilated. The wards were large, dingy and most oppressive in the atmosphere they created. Four years ago one of these buildings, occupied by male patients and condemned as a fire-trap, was made vacant by the transfer of its occupants to two one-story pavilions where they were made very comfortable and much more easily cared for and controlled. (p. 4)

Particular mention was made of the response of the patients, their "change in mental condition and general attitude" (MacEachran, 1956, p. 4) following their move

> from the large, dingy, crowded, noisy, smelly wards which they left, to the quiet, bright, cheerful atmosphere which they now enjoyed and of which many spoke with appreciation and

> thankfulness. The result of the clear recognition of the therapeutic value of proper living conditions making possible more effective nursing, careful consideration is now being given to the possibility of renovating in a similar manner all the disturbed women's wards in the hope of much improvement in the mental condition of these patients and perhaps of reclaiming not a few to a measurably normal life and all that that will mean to them. (p. 4)

The chairman reminded the government that he had served in this capacity since 1920 and concluded his report by commending the "unfailing courtesy, understanding and cooperation that has always been accorded to the Board in its inspections and discussions, by all officers of the Provincial Department of Health" (MacEachran, 1956, p. 9), and verified that

> the public may be sure that the men and women who are active in the Government services in the field of mental health are not only faithfully contributing knowledge and experience commensurate with the continuous and rapid progress of Medical Science, but that interest and devotion which is particularly called out by one of the persistent and most humanitarian of our social problems. (p. 10)

The report of the Visiting Board of 1956 reminded the government of its mandate and its responsibilities to the public, reviewed its previous recommendations, and provided detailed descriptions of the patients' living conditions, with a major focus on the problems of overcrowding at Ponoka.

In 1957, expressing the congratulations of the Board of Visitors to the new Minister of Health, the chairman took advantage of the opportunity to reiterate two major concerns that had been expressed in previous reports. Regarding the first of these, the overcrowding in the mental hospital, he said,

> has plagued the efficiency and progress of the Mental Hospitals since the First Great War. It was hoped that the transfer of 500 to 600 adult defectives to Deer Home, Red Deer, would have relieved the present overcrowding at the Provincial Mental Hospital, Ponoka, and the Provincial Mental

> Institute, Edmonton. Unfortunately, difficulties in construction of the mental defective building have made the transfer of the patients impossible. (MacEachran, 1957, p. 2)

The second major problem identified by the Board was the lack of "a sufficient number of properly qualified Psychiatrists, Psychologists and Social Workers to secure the effectiveness of the Mental Hospitals and Guidance Clinics" (MacEachran, 1957, p. 2). A note of hope was seen by the Board in the development at the university of "a fully organized Department of Psychiatry [which] is undertaking the training of Specialists in Psychiatry" (p. 2). The Board also encouraged the government to develop in the near future "a school for the training of Psychologists and Social Workers" (p. 3).

Remarking that the hospital at Ponoka was "built at a time when such institutions were thought of in terms of custodial care rather than of medical treatment and possible cure" (MacEachran, 1957, p. 3), the Board listed 11 "extensive transformations and important additions" necessary if this institution "is ever to rank as a first class Hospital" (p. 3). These included proper classrooms and equipment for the "Nursing Training School," air conditioning on some of the male wards, a reception unit for male and female patients, remodeling of certain wards, and a chapel.

In spite of the critical comments made by the Board about the facilities and overcrowding at the hospital, the nursing staff were viewed in a positive light:

> The Board would like to give special mention to the Nursing Staff of the Provincial Mental Hospital, for their devotion to duty, resourcefulness in giving excellent nursing care in surroundings which in some instances, at least, leave something to be desired, and for their interest and enthusiasm in their work. In its many contacts with the Nursing Staff at this Hospital, the Board never fails to be impressed by the dedication to the patients which it senses in these staffs.

> It is obvious that the quest for new and better nursing techniques, while still maintaining all that is good in proven methods, never ceases. (MacEachran, 1957, p. 3)

While the overcrowded conditions and lack of treatment facilities continued to be a problem during this period, the decision to introduce the tranquilizers eventually resulted in a major shift in the mission and role of the psychiatric hospital.

The Introduction of the Tranquilizers, Provincial Mental Hospital Ponoka

The interviewees described the circumstances surrounding the introduction of the tranquilizers, the effect of these drugs on the patients, and the response of the staff to the introduction of these drugs. While the elimination of mechanical restraints was preceded by public scandal, the tranquilizers were introduced without fanfare, first on the most disturbed wards and then gradually throughout the hospital.

Although one interviewee thought the tranquilizers were introduced in 1953, and others expressed uncertainty as to the exact date, the majority of those interviewed confirmed that the tranquilizers had been introduced in September, 1954. As Mr. X. recalled:

> It seems to me the tranquilizers were introduced in late 1954, September, I believe. I was on Male Twelve. The staff and patients were given very little information about these drugs. I remember those big brown jars full of tranquilizers, mostly chlorpromazine, in the med. cupboards. Later on, I remember there were some workshops for the nursing staff, put on by the school, I believe. There were a lot of drug studies going on in those days; they would use the drug on some of the patients and a placebo on others.

Noting that he had begun working at the hospital in 1953, Mr. R. recalled his personal experience before and after tranquilizers had been introduced:

> When I first went there I was the junior person on a large ward with an east and a west end. My job was to go and sit in the east end right next to the door and observe the patients. I could talk to the patients and get some of them to play cards with me at the table next to the door. Otherwise, I sat and observed, and the moment a fight started, which happened quite frequently, you opened the door, gave a bellow, and piled in there trying to separate the patients as best you could until other staff got there. With the introduction of tranquilizers in 1954, the east end became more open. In fact, over a period of six to eight months the doors to the east end were opened. The east end was not the east end anymore; it was just another dayroom. People who did misbehave or become aggressive were just placed in the side rooms for a few days until they got control of themselves or until they learned their lesson. As a result, instead of having six or eight in the side rooms on a constant basis, we were probably down to three or four, and the other rooms weren't used that much, more for sleeping rooms at night.

Some staff related that they had received information about the drugs from their head nurse, while others recalled short clinics on the ward about the drugs, particularly a discussion of the side effects. Mrs. L. stated, "It seems to me even the doctors were skeptical. They came to the ward more frequently and kept asking us about changes in patients' behavior." This skepticism was present not only in the physicians, as Mrs. L. recollected that "some of the older staff were sure these drugs were just a passing fad--it wouldn't really change the behavior of the more violent patients. Believe me, were they surprised!"

According to Mr. C.:

> Many of the staff felt confused about the new drugs. We weren't sure what these drugs would produce. Some were very suspicious, particularly the institutional aides who weren't given any information. It shocks me now, but the I.A.s gave these drugs, and we really had to fight to stop the practice. Some of the aides' noses were really out of joint, too, when this so-called privilege was taken away from them.

Some staff had severe allergic reactions to the new drugs, and Mr. C. mentioned, "One staff member had eye damage from working with the tranquilizers. There were lots of staff who had severe skin reactions. I remember one staff member being told she must be neurotic because she had a skin reaction." Yet, for several interviewees, and Mrs. H. in particular, many of the staff became really enthusiastic about these new drugs and "kept wanting to try this and that." Some, she said,

> were so keen that they weren't leaving the patients on the drug long enough to have any effect; they wanted to try another one. I remember there wasn't enough money to buy these drugs for all the patients, so we had to basically decide who would get them first. Of course, we selected the most-difficult-to-manage or violent patients first.

Each person interviewed recalled several patients whose behavior was changed dramatically when they received tranquilizers. One patient in particular was etched clearly in Mrs. J.'s mind:

> I remember A.K. She was a very psychotic, violent lady who would attack you viciously. It would take four or five of us to bathe her. It was so hard to believe, when she was put on tranquilizers she was uncertain in her own way, but she wouldn't strike out. Periodically, she used to verbalize her aggression. She started helping on the ward, going to O.T., and eventually she was discharged. I remember meeting her in Edmonton one day, and my hair just stood right up on end! Old memories die hard! When I got over my shock it was good to hear she was doing very well.

Another former staff member remembered:

> When we saw the effect of the tranquilizers on the patients, we all became more relaxed. Let's just say the old fears weren't there any more. Not that I'm a fearful person. Even before the tranquilizers we saw the patient as an individual and a human being. I think the patient also became more relaxed as we relaxed. I guess we really began to see each other as human beings.

Mr. L. recalled a patient named Harold: "Some of the manic patients were given tremendous dosages. For example, Harold on Male Twelve, he was on twelve hundred milligrams a day. That's enough to kill a horse, but this dosage just kept him from blowing up." Mr. L.

then went on to describe some general problems in prescribing tranquilizers:

> So many times it was very difficult to get the patients on the right dose or the right combination of medications. Usually the head nurse and doctor determined the dose, although when we started having group therapy, some of the doctors would discuss the patients' medication in group with the staff or even with the patient.

Mr. F. recalled a particular patient:

> Charlie used to have five slices of bread per meal. They had to be consecutive slices in the loaf. He had so many delusional ideas, he wouldn't allow anyone to get near him. He also had a short fuse and would get into many fights. After a short time on tranquilizers he became calmer and got out on the ward for longer and longer periods of time. I think he eventually went to Oliver, but the changes in that man were unbelievable.

Mr. H., who worked on the forensic unit for many years, observed:

> On the forensic unit, Male Twelve, there were two patients. One was a very dangerous murderer who would "come out" only for his weekly bath, accompanied by three or four staff. Another guy named Steve D. had been in the side room [Seclusion] for eighteen years; he was very paranoid. They started giving him largactil mixed in his food because this is the only way they could get it into him. Forgive the language, but he was strictly an animal. Anything he wanted to do, you were looking at four to five men hanging onto him. I was one of the smallest and weakest on that ward, so the others were big guys. I can remember, we started giving him the largactil, and in about two weeks, maybe less, but within a very short while, you could notice the change in him. You could start approaching him more, and one day he asked for a paper and a pencil, which was totally unreal, and he wrote a letter to his sister. The gist of the letter was that there was a total blank in his memory of eighteen years. It was as though he had only been in the hospital for a few weeks. In fact, it was something to the effect that "I have been here now so many weeks, I am doing quite well, etc., etc." He came out of the room two or three weeks after the start of largactil and came into the dayroom. He started talking to staff. He became very pleasant, and, in fact, I think it was in less than a year he got discharged from hospital.

A former nurse, Mrs. G., recalled that some of the patients who had been diagnosed as mentally retarded were given tranquilizers, after which, she said, it became apparent that they were, in fact, schizophrenic, not retarded. She concluded this observation by noting that "these cases were a tremendous shock to us all and really made us look at all the patients in a different light."

In addition to changes in the patients' behavior, staff recalled that the patients' behavior toward each other was changing, as noted by Mrs. R.:

> It seems to me that the patients became more tolerant of each other. Normally, on night shift there would be a lot of battles and scuffles. When these new drugs came along, generally the agitation just lessened. Some patients even asked for more medication if they felt they were getting upset. To me, the patients became more of a normal social group.

This change in patients' behavior toward fellow patients was echoed by Mrs. M.:

> So many of the patients became aware of each other and each other's needs. One lady had been catatonic for years. She was tube fed and tied to a post to keep her upright. Otherwise she would lie on the floor and smear. Well, this little Scottish lady said to the nurse, "J. went to the bathroom." The nurse was so startled, she said, "I beg your pardon?" Well, J. started to come out of her catatonic stupor, and she told the nurses all kinds of things that had happened on the unit. She was able to relate specific incidents and identified the nurses who had been kind to her and those that were mean. The other patients and staff all started to respond to her. She really did very well.

All interviewees confirmed that even though the official decision to administer the drugs depended on a doctor's order, this "order" was always written "after the doctor consulted with the head nurse." The head nurse was seen to have a great deal of influence and could "get the doctor to increase the dosage or try another drug." In fact, by reporting certain side effects, the head nurse could easily have the drug and the dosage changed. Six people commented that the staff nurses began to have some input in this area when ward conferences were started on each ward.

All of those interviewed confirmed that the senior institutional aides and graduates administered the drugs. Most of the tranquilizers were given orally, although in an emergency some were given intramuscularly, and with the elderly the pills were crushed and mixed in with the patients' food.

In most cases the drugs were given to the patients without any explanation. The patients simply complied. Exceptions to this unilateral approach sometimes occurred in group therapy, in which the doctor would explain to the patients what drugs they were on and why.

The View of the Medical Superintendent

Many of those interviewed gave credit to Dr. MacLean for bringing information on the new drugs to Ponoka and promoting their use. This view is illustrated in the comments of Mr. J.:

> Having attended a conference in the U.S. I think it was in 1953, Dr. MacLean, who by then was Director of Mental Health, returned to Alberta very enthused about these "new drugs." Dr. MacLean maintained a home and office in Ponoka and in Edmonton. At first Dr. Michie was a little apprehensive about these new drugs, although when he saw the changes in many of the patients' behavior, he quickly became a supporter. I think all the doctors quickly became supporters, especially when they saw the changes in the patients' behavior, but it was really Dr. MacLean who came back and gave everyone information on these new drugs.

Dr. MacLean had been promoted to Director of the Mental Health Divison and was no longer the Medical Superintendent at Ponoka; he did, however, maintain an office and home in Ponoka. It is clear from the above comments that he still had tremendous influence at the hospital. A recurring theme in staff interviews regarding these two critical decisions, the elimination of mechanical restraints and the introduction of the tranquilizers, was the warm regard and respect the staff still held for Dr. MacLean. In 1948 Thomas Michie became Medical Superintendent following Dr. MacLean's promotion to Director of the Division. Whether or not there were any difficulties with Dr. MacLean, the previous incumbent, so close at hand cannot be determined. One can only surmise that the situation would call for diplomacy on the part of both men.

After graduating from the University of Alberta in 1926, Dr. Michie spent three years at the Mayo Foundation in Rochester, Minnesota, obtaining his Fellowship in Medicine (Roberts, 1973, p. 210). He joined the medical staff at the hospital in 1932, and in the intervening years obtained a certificate in psychiatry. Dr. Michie was active in both the Canadian and the Alberta Medical Associations. He was remembered by staff as a "tall, striking man" who, in his frequent public lectures on mental health, gave credibility to the hospital. Miss Edith Kemp, the Superintendent of Nurses, and Dr. Michie were instrumental in arranging a two-month affiliation course in psychiatric nursing for nursing students in general hospitals. He was also credited with the introduction of group therapy as a form of treatment in 1954.

Although the interviewees generally agreed that the hospital began using the tranquilizing drugs in 1954, it is noteworthy that this is not recorded in Dr. Michie's annual report for the year. Perhaps the significance of this can be illustrated by comparing Dr. Michie's comments on "Clinical Work" and the "Conclusions" in his annual reports for the years 1953 and 1954. It may have been that he regarded use of the tranquilizers as "experimental" and felt that it would be premature to report on the results.

> Clinical Work
>
> Every effort was made to have procedures in keeping with accepted standards. The laboratory services were greatly improved. Insulin-shock and electroshock were used extensively with good results. A small number of patients had lobotomy operations, and the results were encouraging. The increase in Medical Staff made it possible to utilize group psychotherapy much more extensively. (Michie, 1953, p. 160)
>
> Clinical Work
>
> This was maintained at a level in keeping with accepted standards. Electroshock and insulin-shock were used extensively, and great emphasis was laid on group therapy. The nursing staff was utilized extensively in the latter method of treatment. (Michie, 1954, p. 3)

In comparing Dr. Michie's comments on clinical work for the years 1953 and 1954, it is evident that electro-shock and insulin therapy were still viewed at that time as the treatments of choice. In 1953 there were several lobotomy operations reported (which involve "cutting the nerve fibers that connect the frontal lobes to the limbic system" [Coleman et al., 1980, p. xi]), but apparently none were performed in 1954. In 1953 the initiation of group therapy by the medical staff is recorded. The movement of nursing staff into group therapy in 1954, formerly the domain of the medical staff, was of great significance. This event changed the role and perception of the nurse, whose activities became less custodial and more therapeutic. The following summations of Dr. Michie's reports for the two years in question provide clear indications of the direction in which the hospital was moving:

> Conclusions
>
> The administration policy of the Hospital was essentially as in recent years. The admission and discharge rates were similar to 1952. The staff was maintained at practically full strength.

> Those responsible for the Hospital administration were appreciative of the cooperation shown by the staff, and for the help and direction given by the senior officers of the Department of Health. (Michie, 1953, p. 162)

> Conclusions
>
> The policy has been toward a gradual and general improvement in the Hospital services. The effort has been directed toward exposing the patients, as far as possible, to normal life contacts, and to so encourage and promote their return to society.
>
> The administrators of this Hospital were highly appreciative and encouraged by the deep understanding shown by and the direction received from the senior officers of the Department of Public Health. (Michie, 1954, p. 8)

Comparison of the "Conclusions" reached by Dr. Michie in his annual reports for 1953 and 1954 reveal a hospital very much in the status quo mode in 1953, and one year later change was evident in two major aims, both reflecting a note of hope and promise of better things to come. The first was the mention of the attempt to improve hospital services generally, and the second was the statement of recognition of the goal of returning patients to society. These reports by the Medical Superintendent failed to mention the introduction of the tranquilizers, but a change in tone and content in 1954 was clearly evident. It may have been that Dr. Michie had adopted a "wait and see" attitude to the introduction of these drugs or might not yet have been fully convinced of their efficacy; or, as noted earlier, he may have viewed the situation as an experiment in process, to be reported on at a later date.

During 1955, the report of the Medical Superintendent indicated that the hospital population had continued to increase, and by December 31 the bed-count had reached 1,589. Seventy-nine deaths and the transfer of 103 patients to other mental institutions in the province were counterbalanced by an increasing number of admissions and the transfer of 61 patients from other institutions.

Dr. Michie (1955) assured the government that "there was little change in the general program of recent years" (p. 81) and then reported that there was

> a progressive policy to increase the freedom of patients, while in hospital. At the end of the year, approximately twenty-five (25) per cent of the patient population had been granted grounds privileges. This was a marked increase over the preceding years. With careful planning, this policy resulted in no administrative difficulties. (p. 81)

A comparison of the superintendents' reports for 1953, 1954, and 1955 indicates increasing emphasis on group therapy as a form of treatment. Reorganization of the nursing staff as participants in this therapy reflected the changing role of the nurse referred to earlier by those interviewed.

> The increase in medical staff made it possible to utilize group psychotherapy much more extensively. (Michie, 1953, p. 160)

> Great emphasis was laid on Group Therapy. The nursing staff was utilized extensively in the latter method of treatment. (Michie, 1954, p. 3)

> Group therapy was emphasized and the results indicated this was of real value. It was noted, during the year, the general behavior of patients was improved. There was a decrease in the destruction of hospital property by patients. (Michie, 1955, p. 81)

The 1955 death of one patient who had received electroshock therapy may have contributed to the discontinuation of this treatment. The pithiness of the first reference to the tranquilizing drugs in 1955 belies its significance: "Extensive use was made of newly discovered tranquilizing drugs, with beneficial effect" (Michie, 1955, p. 81).

The conclusion of Dr. Michie's report for 1955 appeared to have been an effort to allay any concerns the government might have had about the changes taking place at the hospital and reflected his skill as a leader and administrator:

> There were no essential changes in policy, but the treatment program was modified or extended, in conformation with current thinking in the treatment of mental illness. Group therapy was emphasized. Keeping in mind the needs and safety of the patients, it was possible to modify many of the restrictive, custodial measures. With the help of the community locally, and at large, some progress was made in promoting more normal living conditions, by social contacts, for our patients, while in Hospital. The basic aim in treatment has been to return the patients to a productive life, in their home environment, as soon as possible. (p. 85)

Despite Dr. Michie's (1955) assurance that there were "no essential changes in policy" (p. 85), it is clear from this report that major changes were, in fact, taking place. This was evident from the increasing number of patients given access to the community and the fact that "progress was made in promoting more normal living conditions, by social contacts, for our patients, while in Hospital" (p. 85). Dr. Michie's comment on the need to return patients as soon as possible to a productive life in their home communities was another indication of the change in treatment philosophy taking place at the hospital. As mentioned earlier, the custodial orientation of the hospital was gradually being replaced with increasing emphasis on a more humanistic, therapeutic approach.

Continuing in a hopeful vein, the 1956 annual report of the Medical Superintendent recorded a decrease in the total patient population by 64 and a higher percentage of patients who had been discharged, as compared with figures for 1955 (Michie, 1956, p. 93). Dr. Michie also noted, "There was a further extension in the policy of according patients trial leaves with their families. The extent to which this was effected can be judged from the fact that during the year more than 300 patients had leave which extended longer than 24 hours. Seventy-three patients were discharged from leave of absence" (p. 93).

The development of the report's section on "Clinical Work" for 1956 summarizes the above-noted changes:

> There were some modifications in keeping with the current trends in therapy. There was a marked decrease in the use of electroshock therapy. The tranquilizing drugs were utilized to a greater degree. They contributed greatly toward the improvement in the general behavior and feeling of well-being among the patients on the continued treatment wards. The drugs also greatly alleviated the symptoms of the recently admitted and acutely ill patients. There was a low incidence of undesirable side effects from the use of tranquilizing drugs. Insulin-shock therapy was continued, as before. There is still a need for this form of therapy. There was a lessening use of hydrotherapy. There was an increasing utilization of group psychotherapy with benefit to a larger number of patients. Five units of the Hospital were operated as open wards, and approximately one-third of all patients in residence had group privileges. (Michie, 1956, p. 94)

Dr. Michie (1956) was clearly an innovator and an agent of change, but he was also aware of the political and public sensibilities of the time, and this led him to be somewhat cautious in his comments and actions. His 1956 report concluded with two important messages: The first reflected the fact that proper safeguards were being maintained, and the second commented on the changes which had taken place in the hospital. The resounding tone was one of hope:

> There was an emphasis on increased freedom for patients, with gratifying results, but without losing sight of the necessity of proper safeguard for the patient and the public.
>
> In reviewing the record of this Hospital over the past twenty years, there is much to give gratification and to stimulate hope for the future. The educational program has given to the Hospital a highly-skilled Nursing Staff which it is felt would compare more than favorably with that of many similar institutions. It is interesting to note that at the beginning of that twenty-year period the discharge rate was approximately sixty per cent of admissions, and that over the

> intervening years, this rate has gradually increased to approximately eighty per cent in 1956. The crude figures, of course, tell only part of the story, but the last quoted figure is enhanced in interest, when it is realized that in recent years, the number of senile patients has gradually increased; furthermore, in 1956, sixty per cent of the patients who were discharged spent less than three months in hospital. (p. 99)

The annual report of the Medical Superintendent for 1957 (Michie, 1957) indicated that despite the increased use of the tranquilizing drugs and an increase in the number of patients discharged (52), the patient population remained constant at 1,523.

The major changes taking place were chronicled in Dr. Michie's (1957) comments under "Clinical Work" in his report on the hospital:

> During the past year, there was a marked increase in the use of the new tranquilizing drugs, with beneficial results. There was a decreased need for seclusion, and a marked improvement in the behaviour of patients on the continued treatment wards. Many more patients became accessible to group therapy, either recreational, or in a form specifically directed toward rehabilitation. Patients previously confined to wards had access to Hospital therapeutic facilities, and in some instances, it was possible to discharge long-term patients. There was a further decrease in the use of electroshock therapy. Insulin-shock therapy continued to be favoured for certain patients. The aim throughout the year was to extend, as far as possible, the "Open-Door" policy, always keeping in mind the safety of patients and the responsibility of the Hospital to the public. (p. 99)

Dr. Michie (1957) was careful to inform the government of the changes taking place in the hospital, yet in the "Conclusions" of his report he indicated that the tranquilizing drugs offered new hope in the treatment of mental illness:

> During the past year, the policies of administration were not changed. This, however, was the first year the newer tranquilizing drugs were used extensively. Throughout much of the year, approximately thirty per cent of the patient population received these drugs. In combination with other forms of therapy, the results were in general highly beneficial. The need for electro-shock therapy was decreased, but that for occupational and recreational and other forms of group therapy increased. It was possible to accord a much

> greater degree of freedom to patients, and in general, there was a very decided improvement in the social atmosphere of wards. There seems little doubt that these drugs have given new hope in the treatment of mental illness, in many of its forms. (p. 103)

The Medical Superintendent's report for 1957 ended on this positive note: "It can be said with some degree of satisfaction, that 1957 was a year in which progress was made in the treatment and care of patients, and in which hope ran high for the future" (Michie, p. 104).

In addition to specific changes taking place for patients and staff, there was a general feeling of hope throughout the hospital. This new spirit of hope is touched upon in the following section dealing with overall changes in the hospital environment.

Response of the Staff

Generally, staff was impressed with the changes taking place in the patients' behavior after the introduction of the tranquilizers. Some concerns were expressed about the side effects of these new drugs, however, as can be seen from the following comments.

Mrs. L. reflected the views of many staff members:

> So many of the patients put on a lot of weight. It seemed as though their whole metabolism slowed down, and so many of them developed protruding abdomens. Combined with the heavy starch diet, it was difficult to get them to do anything. Many of the patients developed Parkinson-like symptoms--well, we had a pill for that, too. It was terrible, though, to see the patients in that state.

Mr. G. expressed strong opinions as to certain adverse effects. As he put it:

> The drugs not only tranquilized the patient, but, in my opinion, they tended to regress the patient. I'll tell you about a patient on Male Eight. His name was Billy, a real grouch. I can't remember what tranquilizer he was on, but H.R. and I were working afternoons, and we noticed on a week-to-week basis he was becoming more and more total care. It

> didn't make sense to us because he should be able to do a lot more than he was, and we felt that he was trying to do more for himself. He didn't like staff contact in the first place, and yet he couldn't manage himself. He couldn't get his act together, so we finally, after a good deal of discussion, got the doctor to discontinue the drug. Billy told us afterwards that "it was like being in a long, long tunnel, and slowly, day by day, I was getting closer to the light." This may sound strange, but the longer he was off the drug, the more we could see a change in his behavior and his ability to function at a higher level. In about three months he was back to feeding himself and talking with us, which he hadn't done before, and he was describing these experiences. He finally got discharged to a nursing home. He was a really nice old guy with a real sense of independence.

Some research on the use of drugs was initiated at the hospital, and the comments of Mr. B. express his reaction to this research:

> This drug just had a label. I believe the number of three-seven-one-two. I don't think it ever made it to the market; it had horrendous side effects, extra-pyramidal symptoms. Patients were drooling and shaking all over the place. We had to take their blood pressure three times a day, and sometimes it would go sky high, and other times it would be really low. We had to warn the patients not to get up really quickly, or they would faint. Also, there were some staff, not a lot, who would develop allergies to the drugs. I remember Judy D. looked like she had eczema.

Several staff members expressed their concerns about the "double-blind studies" that were done "without the patients' consent." Some of these drugs had terrible side effects such as "drooling" and "sloped walking," and, in the view of the staff, the patients did not always benefit from the drugs. One looked back at these experiments as a very difficult time in her life. "I didn't even know what these drugs were, and I was expected to give them to the patients. I believe some of the patients died from these drugs. I remember one experiment was stopped after one of the patients died unexpectedly."

Some of the staff were particularly upset because the patients seemed "more like zombies than real people." One experimental drug was given a number, and the drug was used on only one ward. Staff members took the patients' blood pressure three times a day, and their concern was voiced by Mr. H.:

> We didn't ever hear what the drug was, but I remember one of the patients was able to come out of seclusion for several hours every day. The patient had been in seclusion for years, so the staff were very apprehensive. We had a sudden death of a patient with this drug, and it was stopped for all patients. We felt terrible about the patient who died, for we were sure it was from the drug, yet we didn't even know what the drug was.

Many of the staff remained apprehensive about these new drugs and had difficulty accepting the changes in the patients' behavior. Yet even they could see the dramatic changes taking place in the patients, and evidently most were excited and pleased about this new development. Concern was expressed about the side effects of these new medications: the Parkinson-like trembling, the drooling, and the rigid posturing. Some staff had difficulty accepting the patients' new behavior and, in Mr. X.'s words,

> continued to treat them in an authoritarian, controlling way. It took a long time for some of the staff to change their behavior toward the patients. It seemed to me they wanted the patients to remain sick; then they could control them. Thank goodness some of these people left the hospital, and the rest of us tried to make life better for the patients.

During the period in which the tranquilizing drugs were introduced (1953-1957), the patient population continued to increase. In spite of this increase, the changes in the patients' behavior and staff response to these changes resulted in profound changes in the organization. The development of group therapy, the movement of patients and staff into community work, the lessening of the noise level on the wards, and the increasing accessibility of patients to therapy created an air of positive excitement in the organization and resulted in a change in institutional character.

Having examined staff perceptions of how the drugs were introduced and the patients' and staff's response, the focus of the study will now be shifted to the changes in hospital practice resulting from the introduction of the tranquilizers.

Changes in hospital practice. Eleven of those interviewed reminded the interviewer of the many patients and staff who, after tranquilizer therapy was available, were able to leave the hospital for a day's work, supervised by hospital staff, either in town or with a local farmer. Mr. G. looked back at this time with great fondness:

> We were finally able to get the patients and ourselves out of the institutional environment. What a change that made for us all. My group used to go out to work on gardens for various people in town. Some of the staff who knew how to stook would work for the local farmers. One day the work was so dirty I took off my own clothes and put on clothes that the hospital supplied to the patients. One of the fellows said, "Gosh, you're just like one of us." They really did treat me as a member of the group, not as staff. What a good lesson that was for me; I never again wore my own clothes or my white coat.

The advent of these drugs led to the female staff "coming to the male side," according to one interviewee, Mrs. L.:

> I remember Miss K. telling me that they had to increase the number of female aides on the male side, as they just couldn't hire males. I don't believe that would have been possible before the drugs came about. . . . Also, the drugs meant that a lot of patients could go downtown on Saturday. It seems to me that we had up to three hundred patients downtown on Saturday. Remember, Dr. M. used to make rounds downtown Saturday afternoon.

Another former nurse, Mrs. G., mentioned that the safety factors for nurses were completely changed. With the violent patients "they might remain uncertain, but they wouldn't attack you any more."

Mrs. V., a nurse at the hospital for 25 years, remembered that "the tranquilizers changed the face of psychiatric nursing," the drugs having made patients more relaxed and more approachable. She said that the patients were "more capable of concentration, and the nurses were able to maintain the patients' interest for longer periods of time," and added that many of the traditional treatments such as seclusion, hydro, ECTs, and lobotomies were no longer used as frequently or were discontinued. As was previously emphasized by Mrs. G., Mrs. V. noted that some of the patients who had been diagnosed as mentally retarded because of their behavior were then seen as schizophrenic and were, with the new medication, able to attend school. In addition to learning how to read and write, she said, they learned more appropriate behaviors.

The situation in regard to the introduction of the tranquilizers was summed up by Mrs. M.:

> It seems to me that the nurse's role changed from being a custodian to a more therapeutic role. Let's face it, what could you do with a hundred and fifty patients and five staff! Instead of making sure that patients kept their clothes on, brushed their teeth, and went to the bathroom on time, we became more of a companion and a friend. We started having groups, and these groups were very therapeutic. Often nurses were group leaders, and nurses felt better about themselves because they were actually helping the patients. The wards were also much quieter; we saw the better side of the patients, and I'm sure they saw the better side of us because we weren't nearly so frightened. In general, I guess things were less barbaric.

Many of those interviewed confirmed that "the hospital became quieter with the use of the tranquilizers," and, as one put it, "we were able to interact in a more therapeutic way with the patients."

As mentioned in a previous section, the development of group therapy was seen as a major turnabout following the introduction of the tranquilizers. Some staff had resisted, as "they felt group therapy wasn't any good." The resistance was short lived, however, and, once group therapy was started, as Mrs. R. reported, "it seemed to develop a life of its own, and eventually every ward in the hospital had groups, ranging from the most chronic patients to the admission area." It was confirmed by many of those interviewed that ECT was "practically stopped," and the nurses "developed more clearly defined therapeutic roles." Even the ward aides had groups, "not at the same level as the grads, but some of the aides were excellent."

Mr. G. looked back on this time and pointed out another significant change:

> Insulin therapy was stopped in 1961. We really didn't need it any more, and it was very risky putting the patients in a coma. Sometimes we had a hard time getting them out of the coma. We didn't have the proper facilities to carry out this treatment, although I believe the patients responded very well. When I look back at it now, it was probably the result of having some attention paid to them and not the insulin!

Many interviewees remembered the development of remotivation therapy in the hospital. This therapy recognizes the uniqueness of each person in the group, is conducted in a nonthreatening environment, and focuses on "the unwounded part of the personality" (MacDonald, Steibelt, & Elek, 1975, p. 1). The use of remotivation therapy was confirmed in the comments of Mr. T.: "I remember that M.C. and G.H. were sent away for a course. I believe it was about 1954 or '55 when they came back, it seemed to me that everyone in the hospital took the course." These groups were held with all the patients, and as one put it:

> the whole atmosphere at the hospital changed to become more therapeutic. When staff groups came in, people really got to know each other and were made more aware of how their behavior affected the patient. I believe the hospital was very therapeutic at this time.

The positive response of patients' families to improvement in their loved ones was a happy memory for Mr. J.:

> This patient, Mrs. S., was in seclusion for what seemed like years. We tried to get her out many times, but she was always so impulsive and dangerous, she had to go back in. She was always shouting, and we were all terrified of her. After about three months on tranquilizers she was a different person. I remember her uncle coming to visit her and breaking down and crying. He couldn't believe the difference. Her whole family started to come and see her regularly. Oh, she was still a hostile person who would still get angry and shout, but she wouldn't strike out. She eventually was sent to Claresholm.

Several of those interviewed alluded to the problem of obtaining enough funding to pay for the tranquilizers. "It seems to me," Mr. F. mentioned, "there was a problem in purchasing the tranquilizers, as these drugs had not been planned for in the yearly budget, and the dispensary budget was quickly spent." There was no indication, however, that the patients did not receive tranquilizers because of budgetary restrictions. Rather, as Mr. F. recalled, "We simply took money out of the clothing budget for patients, or something like that, and put it in the dispensary account. Also, we had to decide who would get the drugs first, so obviously it was the most difficult-to-manage people first."

Another interviewee, Mrs. E., recalled that Dr. Michie, the Medical Superintendent of the day, had felt that the staff would not see the same dramatic results as at other hospitals "because the nursing care we gave was so good," although "I certainly remember people coming out of seclusion who had been in seclusion for ages."

According to Roberts (1973), the introduction of the tranquilizers resulted in "an almost dramatic lessening of destruction, such as broken windows, broken dishes, torn bedding and apparel" (p. 202). This change in patient behavior was accompanied by a dramatic decline in the use of electro-shock therapy, a reduction in the seclusion and segregation of patients, and an increase in freedom for patients and staff.

The community was also affected by the introduction of the tranquilizers and the changes taking place at the hospital. Data obtained from staff interviews, newspapers, and documents present a picture of the increased interaction of the hospital and community.

Changes in community response to the hospital. The changes in the patients' behavior as a result of the tranquilizer drugs resulted in increased freedom for the residents of the hospital. With the advent of the tranquilizers, the number of patients in the town of Ponoka on a Saturday quickly increased from 10 to 300, according to reports from former staff members.

Staff interviewed held two opposing viewpoints about how the town reacted to the increasing number of patients seen in downtown Ponoka. Nine believed that the business people were generally very supportive of "letting people out," and there were good working relationships between the hospital and the community. Six people commented that Dr. M., the Medical Superintendent, acted as liaison between the hospital and the community. Mrs. A. stated: "On Saturdays you would see Dr. Michie walking downtown; he was there if needed. It seems to me that this also gave the town a message that the patients were down there with Dr. Michie's approval." A number of patients became active in the local churches and did odd jobs around town. Many of the locals were said to have wondered, "What's going on up there, letting these people out?" Several recalled incidents with business people, for example, when one of the patients had taken something out of the store; the hospital was phoned and the caller was very angry. As one interviewee said, "We really had to use our P.R. skills in those cases." Others recalled patients going to work for local farmers in addition to hiring out for general yard and garden work in the community.

Further evidence of the hospital moving toward more therapeutic care and attempting to educate the public can be seen in an article by reporter Don Smith (1954), entitled "Alberta's Mental Hospitals Rarely Use Strait Jackets," appeared in the December 28 issue of The Edmonton Journal. The writer provided the public with a short history of treatment in Alberta's "mental hospitals" and stressed that "only long service employees of Alberta's mental hospitals would know how to use a strait jacket--if there were any to use" (p. 5). In a portrayal of the "modern concept of treating mental patients," the public was informed that many of the patients shopped in town and attended local sports events. The public was reassured that

> mental hospitals are no longer asylums, places of retreat and refuge, nor are they merely custodial institutions. Patients are placed in mental hospitals for active treatment of their ills and, in many cases, with the full expectation of complete or partial cure. (p. 5)

An interview with a hospital physician confirmed these new attitudes and aims of treatment. As he put it, the goal was "to give the patient as normal a pattern of living as is possible, within an institution." A succinct explanation was given as to why people come to mental hospitals: "Generally, persons come to a mental hospital because of a breakdown in their interpersonal relations. It is our job to restore their ability to live and work with other people" (Smith, 1954, p. 5).

This "opening of the door" of the hospital to the public, and demonstrating pride in its accomplishments, were illustrated in the

Jubilee edition of The Ponoka Herald, September 20, 1955 ("The Provincial," p. 7). The history of the development of the hospital was recorded, and the public was reminded that "Ponoka can justly claim to be the centre of the province's wide-spread mental health program comprising, in all, six institutions, two child guidance clinics and traveling clinics the length and breadth of the province" (p. 7).

While this writer gave the hospital credit for being at the forefront of treatment, he failed to record the introduction and widespread use of the tranquilizers:

> Forms of treatment have kept pace with the growth of the institution. Hydrotherapy has been used since the beginning. Malaria therapy for treatment of syphilis of the nervous system was begun in 1924 and was used continuously for 26 years. It was discarded in 1952 and penicillin and electric fever therapy substituted.
>
> All forms of mechanical restraint were abolished in this hospital in 1937--a fact that may come as a surprise to many people, and an indication of the progress made in mental health treatment from the early days of mere confinement to the present when the emphasis is on healing.
>
> In 1937 insulin therapy was inaugurated but had to be discontinued during the second world war because of shortage of medical staff. It was re-instituted in 1947 and has been used with success on selected groups. Electro-shock therapy was begun in 1943 and has become one of the major forms of present-day control and cure of mental illness. It is used extensively. ("The Provincial," 1955, p. 7)

As is reflected in a story in The Ponoka Herald of October 19, 1955 ("PMH Happenings"), the increased freedom for the patients was accompanied by community donations which served to humanize the social environment of the hospital:

> Two P.M.H. wards have recently "struck it rich" through the generosity of public-spirited citizens. Dawnview male "open ward" had the good fortune to receive from Mr. Charles Lewis, the record player which he won through the Legion raffle. Ladies' ward 6 has acquired a record player and nice supply of records through the good offices of the Ponoka Kinette Club. Should anyone have records on hand which they would like to put to a good use, they would be a very welcome addition on either or both of the latter wards. (p. 5)

The Edmonton Journal for 1956 carried several articles on mental health. Two are of particular significance for the purposes of this study. A Journal staff writer, Al Rowe (1956), stated, "Mental ill-health is becoming one of the most pressing health problems facing Canada--more than half the hospital beds in the country are occupied by mental patients" (p. 6). Readers were informed that the Provincial Mental Hospital Ponoka "is the main institution for mental patients" in the province. The author called attention to the overcrowded conditions, informing the public that the hospital had a rated bed capacity of 1,180 and a patient population of 1,500.

Rowe (1956) noted that in a comparison of Alberta's and Saskatchewan's mental-health systems, Alberta's shortcomings were all too apparent. With the two provinces having the same number of patients, staffing levels for the two were compared. Alberta had 3 qualified psychiatrists, while Saskatchewan had 13; Alberta had only 184 qualified psychiatric nurses, compared to Saskatchewan's 345.

Alberta was judged to be deficient in providing mental-health care to its citizens, and Rowe (1956) concluded on this rather pessimistic note:

> The assessment of existing mental health facilities falls into two groups: housing of patients, and treatment of patients. Alberta is relatively well situated from the standpoint of accommodation--only Ponoka can be described as over crowded. However, there are not enough trained personnel in provincial institutions to give adequate treatment, and the situation may well become worse, since the rate of increase in mental hospital populations is continuously accelerating. (May 7, 1956, p. 6)

An article entitled "Citizens Asked to Help Cure Mental Patients" (1956) provides some insight into the movement to "release patients" from mental hospitals. In an Edmonton public meeting, the Executive

Director of the Saskatchewan division of the Canadian Mental Health Association emphasized the need to place the emphasis on rehabilitation in mental-health work and expressed concern that even though a large percentage of patients was discharged into the community, "51 per cent of them had to return for further treatment" (p. 13). In the speaker's opinion, "the hospital did a good job but the community didn't" (p. 13). The public was urged to participate in resolving the present problems in mental health. Suggestions included increasing public awareness, uncovering prevailing conditions in mental health, and encouraging public demands for improvements by the government.

Reports in The Ponoka Herald for 1956 indicated increasing involvement of the community in enhancing recreational activities for patients. The need to establish an apparel shop was further evidence that increasing numbers of patients were being discharged. The opening of this service and the accompanying fashion show were fully documented in the December 18, 1956, issue of The Ponoka Herald ("PMH Starts"). Dr. Michie opened the event and explained to those attending that people came to the mental hospital "because they were unable to meet the stresses and strains in a home environment." In his view, the hospital's role was to remove these stresses and strains. To prepare patients to return home and to meet the problems of life, he said, it was necessary to create a homelike environment in the hospital. Supporting the opening of the apparel shop, Dr. Michie emphasized that,

> where possible, patients should be equipped with their own clothing and effects, since it is part of the routine of living to think in tune of one's clothing and appearance; however, in cases where it was not possible to obtain "special" items from relatives or friends, it was most helpful to have a supply from other sources. (p. 7)

The movement of patients into the community and the community into the hospital is reflected in the representation of community groups who attended this function and in the patients' taking the roles of models, commentators, and pianists. A remark by a staff member who had been at the hospital for more than three decades reflected enthusiasm for the changes occurring in the hospital at that time: "Looking back thirty years, would you even have believed something like this would take place?" ("PMH Starts," 1956, p. 7).

The year 1957 began on a positive note, with the leadership provided by Dr. Michie in the hospital and in the province recognized by his election as President of the Alberta College of Physicians and Surgeons. The headlines of The Ponoka Herald for February 12, 1957, "Dr. T. C. Michie Brings Honour to Ponoka," and the lengthy article on his life and work acknowledged the respect Dr. Michie had earned. A description of Dr. Michie's role as chief administrator of the hospital provided the reader with some insight into the situation at the hospital and the personality of its Medical Superintendent:

> As Chief Administrator, Dr. Michie has striven to maintain and further the established policy and tradition of rendering the most modern forms of psychiatric treatment to the patients, while at the same time doing everything possible to foster the comfort and contentment of those who must of necessity remain in hospital for longer periods. When one considers that some 1,600 patients are Dr. Michie's direct responsibility, as well as the supervision of approximately 500 staff members, it can readily be understood that his position is not an easy one. Within the very recent past it has been possible for him to obtain the services of several additional physicians, thus increasing the medical staff to twelve. He now feels that it will be possible to further raise the standard of treatment and care of the patients, and he has extensive plans along those lines. (Section 2, p. 1)

The concluding remarks in this report commented on Dr. Michie as a person:

> Not only the patients in his Hospital, but their many relatives and friends throughout the Province, have learned to appreciate and respect Dr. Michie's ability as a Psychiatrist, his excellent judgement and perhaps most of all, his humanitarian approach to the many problems with which he is confronted each day. (Section 2, p. 1)

There was some attempt during 1957 to educate the public about the new tranquilizing drugs. In an article in The Edmonton Journal, a spokesman for the Canadian Medical Association warned the public that "the sale of the tranquilizers was increasing at an alarming rate" and that these drugs could cause addiction ("Restrictions," 1957, p. 32). In a follow-up article a physician recognized that these new pills "had some value in the treatment of mental disease and alcoholism," but he charged that "the vast majority are being taken frivolously by healthy people trying only to escape the normal tensions of everyday life" ("Doctors, Druggists," 1957, p. 1). These comments by a physician outside the psychiatric community indicate that, as late as 1957, there were still many unanswered questions about the tranquilizers in the medical community. The conservative members of the Canadian Medical Association were not ready to give their unqualified endorsement to the new tranquilizers until it was clear that the benefits clearly outweighed the possible negative effects. As a member of this organization, Dr. Michie was perhaps reflecting the policy and concerns of his professional group in not mentioning the introduction of the tranquilizers until his 1955 annual report.

The Board of Visitors, also exercising caution, made its first public comments on the tranquilizing drugs in its annual report of 1957:

> The Medical Superintendent told the Board that the new tranquilizing drugs had been used very extensively with good results. It was pointed out that although this was an expensive form of therapy, a considerable saving had been effected in that the patients were much less destructive than formerly. (MacEachran, 1957, p. 11)

Summary

The publication of several studies during the early 1950s on the negative social effects of mental-hospital incarceration on patients and staff resulted in some self-examination by the staff on conditions at the hospital. It was the introduction of the tranquilizers, however, that made it possible to extend the movement of the hospital from its custodial orientation to a more therapeutic one. Increased levels of staff education assisted the move. The opening of the hospital doors to public scrutiny resulted in public and media support for attempts to change the organization from its characteristic incarceration role to a more therapeutic one.

As the hospital became more open to the community, so too the community became more open to the hospital, with patients and staff providing some labor for local farmers, particularly during the harvest season. Townspeople were contracted for various labor jobs, including gardening, lawn maintenance, and clean-up projects.

The leader, instrumental in bringing about changes, was careful to keep the politicians informed. The potential for a political mine field was evident if "things" went wrong. Dr. Michie's annual reports documented the changes taking place at the hospital. There was an educational component to these reports, as he explained the general changes taking place in the mental-health field and related them to what was happening at Ponoka. It would appear that Dr. MacLean, the Director of the Division of Mental Health, assumed the role of innovator, bringing information about the tranquilizers to Dr. Michie, the institutional leader. While there is no evidence to support the notion that Dr. Michie was resistant to the idea of utilizing the tranquilizing drugs, his failure to mention their introduction in 1954 may indicate that he had some hesitation about their use or simply did not wish to publicly acknowledge their use in light of the stated position of the Canadian Medical Association.

It would appear that the organization, which for the last 50 years had been in the horse-and-buggy era, now had the gasoline to change but did not have the horseless carriage. Overcrowded buildings designed for incarceration did not lend themselves to developing programs focused on small-group work, an increase in personal privacy, and respect for the rights and freedom of patients. Although some staff were reluctant to change their old authoritarian attitudes, for the majority there was a genuine attempt to change the institutional character from a custodial orientation to a more therapeutic approach.

Chapter 7

Deinstitutionalization: 1967-1975, Alberta Hospital Ponoka

Deinstitutionalization, the third and final critical decision examined in this study, involved the transfer of large numbers of long-term patients back into the community. This chapter, covering the years 1967 to 1975, begins with a discussion of the prevailing beliefs and systems of care in place nationally and internationally. In the next section a series of staff interviews presents a picture of the Ponoka Hospital as it was during the late 1960s prior to deinstitutionalization, followed by a chronicle of the events which resulted in the government's decision to conduct the mental-health study, with the resulting deinstitutionalization of Alberta Hospital Ponoka. The role of the institutional leader is explored as an integral part of the process. Public and community response to publication of the Blair Report are examined in the following section. Finally, the Summary reviews the factors which led to the emergence of the issue, its resolution, the role of the leader in these events, the resulting adaptation of the institution, and the redefinition of its institutional mission and role.

The National and International Scene

Prior to the 1950s the organization most representative of what society believed was the appropriate vehicle for the care of the mentally ill was the large mental hospital. During the 1950s the publication of several research studies (Caudill, 1958; Schwartz & Will, 1953; Stanton & Schwartz, 1954) brought the problems in these institutions to the attention of the public. The isolation of the staff and patients, the authoritarian and overregulated atmosphere of the institutions, the lack of funds, and the custodial care of the patients were characteristic of the generally stifling, deadening, and antitherapeutic orientation of the institutions.

The debilitating effects of the incarceration of patients in the large mental institutions continued to be the subject of much concern during the 1960s. In the view of Goffman (1961), Wing (1967), and Barton (1966), factors operating within the institution and the patients' and staff's limited contact with the outside world contributed to the patients' dependency, loss of interest, and fear of the outside world.

The publication of Goffman's (1961) insightful analysis of a mental hospital received much public acclaim and prompted some attempts at reform. In an earlier era the same response had been received by Beers' (1908) A Mind That Found Itself, a book which documented his experiences as a patient in a mental hospital.

In describing the mental hospital as a "total institution," Goffman (1961) defined its role as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period, together lead an enclosed, formally administered round of life" (Introduction). Goffman observed that the patient, after entering the hospital, might hold himself aloof, refuse to enter the visiting room when relatives visit, avoid talking to anyone, or become mute. A possible explanation for this behavior (in Goffman's view) is that the patient "may very strongly feel the desire not to be known to anyone as a person who could possibly be reduced to these present circumstances" (p. 146).

The mental hospital setting was viewed by Goffman (1961) as "treacherous." Staff members, in their attempts to gain the patient's co-operation, convince the patient that he is a failure and that the claims he makes about himself are false. Goffman pointed out that the staff has much to gain by discrediting the patient's story, for

> if both the custodial and psychiatric factions are to get him to co-operate in the various psychiatric treatments, then it will prove itself useful to disabuse him of his view of their purposes, and cause him to appreciate that they know what they are doing, and are doing what is best for him. (p. 155)

Based on his studies of mental hospitals in England, Europe, and America, Barton's (1966) booklet Institutional Neurosis reinforced the findings of earlier studies on institutional life. This eminent British psychiatrist identified "the apathy, loss of interest, lack of initiative, and sometimes a characteristic posture and gait" (p. 12) seen in people confined to institutions, the result of "institutional life." He described the condition as a "mental bed sore" (p. 12). When confined to an institution the patient experienced (1) loss of contact with the outside world; (2) enforced idleness; (3) bossiness of the medical and nursing staff; (4) loss of personal friends, possessions, and personal events; (5) prescription of drugs; (6) authoritarian ward atmosphere; and (7) loss of prospects outside the institution (p. 17). These seven factors, combined with loneliness, cause the person to lose hope of a life outside the hospital, "becoming more apathetic than the situation demands" (p. 27).

Barton (1966) developed a seven-step treatment program for institutional neurosis. Treatment began with the patients working in small groups, continued until the patients were working full time in the community but living in the hospital, and, finally, resulted in former patients living in the community, no longer attached to the hospital.

The term institutionalism was utilized by Wing (1967) "to describe any behavior which is evoked in an individual by the social pressures of an institution" (p. 219). This author noted that "prolonged segregation will produce a syndrome marked by apathy, resignation, dependence, depersonalization, and reliance on fantasy" (p. 220). The hypothesis for this study stated that "there is a gradual deterioration over many years in the attitudes and behavior of schizophrenic patients who are aged fifty-nine and under and who have already spent at least two years in a mental hospital" (p. 226). The study took place in two London hospitals, and random samples were taken of half the male chronic schizophrenic populations under 60 years of age. Although the clinical examination revealed "very little relationship" between length of stay and "symptoms of the illness" (p. 235), Wing found that "there is a progressive increase, with length of present stay, in the proportion of patients who appear apathetic about life outside hospital" (p. 234).

There appeared to be general agreement among writers about the debilitating effects of long-term hospitalization of the mentally ill. According to Appelbaum (1986), the burdens of increased immigration, the continued expansion of mental hospitals, and lack of adequate funding combined to ensure that these public institutions became "enormous holding units, to which the mentally ill were sent and from which many never emerged" (p. 35). For this writer, the mentally ill had slid "to the bottom of the list of social priorities" and "were often treated with brutality" (p. 35).

In Appelbaum's (1986) opinion three factors were instrumental in the development of the deinstitutionalization movement. The first occurred as a new generation of psychiatrists returned from World War II. Rapid-treatment models were introduced close to the front lines during the war, and they had been effective in cutting the morbidity of psychiatric conditions. These psychiatrists began to push for reform in the institutions: Patients were prepared to return to the community, locked doors were opened, active-treatment programs were initiated, and the growth of the mental institutions began to reverse. Second, the discovery of chlorpromazine in 1952 made it possible to control the symptoms of the severe psychoses, and patients were able to live outside the hospital. Third, proponents of certain ideologies began to promote the treatment of patients in their respective communities. These people included psychiatrists who declared that mental patients should not be confined to large institutions for long periods of time and civil-libertarian attorneys who sought to eliminate all coercive treatment of the mentally ill, resulting in the dismantling of the large institutions. The publication of books such as Goffman's (1961) Asylums, Szasz's (1961) The Myth of Mental Illness, and Laing's (1960) The Divided Self all contributed, in Appelbaum's view, to the development of the deinstitutionalization movement.

The term deinstitutionalization was defined by Beck, Rawlins, and Williams (1984) as,

> at the individual client level, the transfer to a community setting of a client who has been hospitalized for an extended period of time, generally many years; at the mental health care system level, a shift in the focus of mental health care from the large, long-term institution to the community-based care, accomplished by discharging long-term clients and avoiding unnecessary admissions. (p. 1448)

Bachrach (1976) identified two elements of deinstitutionalization: (1) the eschewal of traditional institutional settings--primarily state hospitals for the care of the (chronically) mentally ill, and (2) the concurrent expansion of community-based services for the treatment of these individuals (p. 1). The movement (deinstitutionalization) has not been without its critics. Dumont (1982) noted, "This thing 'deinstitutionalization' is nothing more or less than a polite term for the cutting of mental-health budgets. Under a patina of community health rhetoric we are returning to a pre-Dorothea Dix situation" (p. 367). Schull (1981) also supported the economic view for decarceration, stating, "It reflects structural pressures to sharply curtail the costly system of segregative control, once welfare payments, providing a subsistence existence for elements of the surplus population, make available a viable alternative to management in an institution" (p. 436). Etzioni (1969) viewed deinstitutionalization as a "policy fashion" that "romanticizes the benefits of community-based care" (p. 9), and Appelbaum (1986) remarked that the policy of discharging patients was for some patients "a blessing." For all too many others, it was "the ultimate curse" (p. 39).

Alberta Hospital Ponoka: Predeinstitutionalization

Many of those interviewed recalled the 1960s as a time of transition and change. As Mr. X. stated, "It was sort of, where do we go from here? It seemed to me the hospital was as therapeutic as it was ever going to be with limited budgets and overcrowding."

Mr. J. recalled that

> we did have a lot of groups for patients in the hospital--we were trying to be therapeutic. It seems to me there were over a hundred groups, all at different levels. The group I was involved with met every day, five days a week. We spent the whole day together--just like a family--cooking, cleaning, and working together. Dorothy [the hospital psychologist] came over and helped with our daily group session.

Mr. J. observed that "I believe the hospital was ready to move ahead, but the old buildings, the big day rooms--impossible! We used attics on the wards to hold our group sessions."

This lack of space and the state of the buildings was a recurrent theme. Mrs. J. stated: "There was even a lack of space to hold any kind of function. The building was too small. Recreational facilities were limited. As usual, mental-health funds were a low priority with the government."

Eight of those interviewed recalled their personal involvement with groups with great delight. Mr. J. commented:

> It was a real honor to be selected as a group leader--and there was a lot of competition among the nurses. For some, it was the idea that you would work straight days. I really got to know the patients in my group, and they got to know me as a person.

Many of the respondents mentioned the various people who headed the groups, but two names came up consistently: Dr. David Phillips and Dr. Dorothy Crouse. Dr. Phillips was the Director of Clinical Services and was seen as the leader of any therapeutic endeavors at the hospital. Dr. Dorothy Crouse, Director of the Psychology Department, worked closely with Dr. Phillips and the nursing staff to implement therapeutic groups at the hospital. Mrs. I. recalled:

> You remember Davie. He really cared about the patients. He not only promoted therapy but expected you, if you had a good idea, to go ahead with it, not wait for him to okay it. He

> not only promoted therapy, but getting patients out of hospital. He taught all of us as students to respect the patients and to care for them.

Mrs. A. reminisced about these times and the leadership provided by Dr. Crouse:

> It seemed to me we all learned how to do group therapy together. Dorothy [Crouse, a psychologist] and Davie were very active in getting us away for sensitivity training. Remember, it was the sixties, and everyone was into human relations training. We had to pay all our own expenses for ten days of this training in Banff. We came back and started to do groups on our wards.

The Medical Superintendent, Dr. J. Byers, was perceived as a very good administrator by the interviewees. He did not participate in the various groups in the hospital, and the feelings of the staff are reflected in the following statement by Mr. X: "He was not really into groups. He didn't stop any groups, so I guess he condoned group therapy. There wasn't any expectation on our part that he would participate."

Twelve of those interviewed mentioned the active role of the Council for Groups in promoting group therapy throughout the hospital. Mr. J. recalled: "We all had a chance to report on our groups at the monthly meeting. There was a lot of support. We also had a lot of inservice education on groups."

Although many of those interviewed described the emergence of group therapy as a major treatment in the hospital, the continued overcrowding and the deterioration of the buildings were a concern. Seven interviewees noted the overcrowding and mentioned the concerns of the community about the role of the mental hospitals:

> We seemed to be constantly admitting patients. Although there were discharges, the count never seemed to go down. It was nice for the people who were group leaders and could go off the ward, but for the rest of us, we were still short of staff and had too many patients.
>
> We wondered about the number of patients. Here we thought we would all lose our jobs when the tranquilizers came in. The building kept getting older and older, the roofs were leaking, water was running down the walls, and we still had the same number of patients.

Mr. S. reflected on the situation at the hospital:

> Yes, we were doing limited therapy with the staff we had, but we were also aware that many questions were being asked by the public and the government about the role of the hospital. Still the patients kept coming in. Many of us wondered what would happen, what would be the final outcome.

The hospital appeared to be in a state of limbo, although attempts were made to improve conditions for the patients and there was an increase in the amount of treatment, particularly group therapy. The patient count, the number of admissions, and the shortage of staff were negative factors in the attempt to improve the situation for patients and staff. As the late 1960s approached, the worldwide deinstitutionalization movement which saw large numbers of mental patients discharged into the community was about to spread to the Province of Alberta.

In Alberta the publication of Premier Manning's (1967) "White Paper" during Canada's centennial year promised "the development of new and positive approaches to the future requirements of the people of Alberta" (p. 17). Of particular interest for purposes of this research was the government's commitment to human resource development. In this area the government recognized that the development of the human resource potential of Albertans took priority over the development of physical resources and was dependent on the physical and mental health of its citizens. Promises were made to develop supportive and preventive health services and to "strive to provide for those individuals suffering from permanent physical or mental disabilities, programs for care and training which will stimulate their interest and respect their dignity" (p. 83).

The Decision to Deinstitutionalize the Mental Hospitals

Early in January 1967 a series of articles in The Edmonton Journal brought to the attention of the public problems within the mental-health system. The reporter, Karen Harding (1967a), began by comparing the mental-health services available in Alberta with those in British Columbia. The services in Alberta were found to "lag behind those in other provinces in both treatment methods and facilities." The writer identified three areas in which to "lay blame for the lack of advancement in the care of the mentally ill in Alberta" (p. 1).

The first reason identified for the lagging state of mental-health services was public apathy, fear, and ignorance based on misinformation, resulting in mental hospitals being isolated and, as it was said, "left to rot, and the patients in them to be all but forgotten." Next, the Department of Health was taken to task for failing to provide the necessary leadership in recognizing the problems faced by local mental hospital administrations. The final point raised by the writer addressed staff who worked with patients. Staff was found to "maintain the status quo" and was criticized for not speaking up about "the needs and well being of their charges" either to the public or to the Mental Health Division (Harding, 1967a, p. 1). This series of five articles, accompanied by photographs, depicted the overcrowded conditions, the lack of certified psychiatrists, staff shortages, and the lack of privacy for patients. The writer charged that other groups "such as the Canadian Mental Health Association, Alberta Division and Edmonton branch, nurses and doctors, and citizens' organizations have repeatedly requested change through briefs and letters, but to no avail" (Harding, 1967b, p. 20).

In a lengthy press release the Canadian Mental Health Association Alberta, through the office of its President, praised the newspaper series by Harding and stated that it reflected "much hard work and careful research on her part" ("Mental Health Group," 1967, p. 1). Agreeing with Harding's findings, the Association noted that it had pointed out the same problems to the government and pressed for change which, in its opinion, was long overdue. The Association was concerned that exposing these conditions to the public might cause stress to patients and relatives. In addition, it called attention to the inability of the Division of Mental Health to "attract and keep qualified personnel" but commended "those who in the face of many difficulties have success in providing some very excellent services" (p. 1).

The Association stated its belief that it represented the citizens of the province and thus reflected public opinion. Furthermore, it requested that the government act on the recommendations presented to it in May of 1966. This brief urged the government to set up a committee to study mental-health services in the province, and suggested that citizens' boards be developed to run mental hospitals and that mental hospitals seek accreditation. This brief was supported by Dr. J. Byers (Medical Superintendent of the Ponoka Hospital), and many organizations in the province (Harding, 1967b, p. 1). Citizens were urged to "inform the Minister of Health and your elected representatives how you feel and where you stand." The public was urged to support the Association "in our attempts to bring about necessary change and for the development of a progressive treatment philosophy within the Division of Mental Health" ("Mental Health Group," 1967, p. 1).

The Alberta Association of Registered Nurses also praised the articles, noting that the reporter, Karen Harding, through her "forthright and objective assessment of mental-health services, further pinpointed the fact that the patient suffering from mental illness does not receive the same excellence of health services as quickly, easily and efficiently as the patient suffering from physical illness" ("Mental Health Series," 1967, p. 21). The nurses urged that the mentally ill be treated with dignity, have access to active therapy, and be treated in the community.

Continuous pressure was applied to the government via the newspapers to initiate reform of mental-health services. Several unsigned letters to the editor of The Edmonton Journal supported the problems identified in the Harding articles. One person, who signed himself "20th Century Psychiatrist," stated the problem was that the government had failed to recognize the change in the relationship "between professionals and their government." Thus, he added, governments have attempted

> to maintain the status quo by appointing the last survivors of the dying breed of civil servant-psychiatrists to senior positions. These men who usually do not have the respect and confidence of their colleagues are supposed to try to continue to operate established services which are based on 19th century philosophies, at 19th century levels of care. ("Letters to the Journal," 1967, p. 45)

The Canadian Mental Health Association did not receive a response from the government to its first request for a meeting. Once again, the Association requested a meeting with Premier Manning and Health Minister Dr. J. D. Ross ("Meeting," 1967, p. 19). The Minister of Health found himself under attack by the Opposition and was asked to defend his remark that "lack of knowledge" accounted for much of the criticism in the Harding articles. Dr. Ross clarified the previous statement by saying, "Mrs. Harding did not write from lack of knowledge, but she didn't make use of all the information available to her" ("Mental Hospitals' Progress," 1967, p. 1).

The relationship between the government and the Canadian Mental Health Association's Alberta Division was said to have become "severely strained." At the annual meeting in Red Deer, the Association's president, Mr. Glenn I. Brant, recognized this and expressed his regret. He noted, however, that the Association was making an effort to obtain better services for mental patients but that this situation was "one of the risks of taking a firm stand on these issues." The Association clearly was not "backing off" and further commended Harding for her "excellent series of articles relating to the situation in Alberta," which had "put clearly and forcibly before the public and has stimulated much thought and discussion" (Harding, 1967c, p. 17).

The lack of adequate mental-health services in the province continued to dominate newspaper coverage of the day. Staff members at the Alberta Hospital in Ponoka, however, had some difficulty recalling these events. Eleven could not remember the factors which led to the Blair study. Some made comments such as "Oh, I suppose there was a scandal, but I don't remember"; and "I think the opposition was really pressuring." Another observed, "It seems to me there were a lot of factors. Maybe the public was showing some interest, but I really don't remember."

The remaining four interviewees were more specific in their comments: "Groups such as the Canadian Mental Health Association were pushing for reforms in mental health"; "Lougheed really got on the mental-health bandwagon. It seems to me he even visited the hospital and promised changes if he were elected"; and "Did the CMHA come out with a report? It seems to me they did. Anyway, I remember they were pressuring for changes." In concluding his comments, the fourth interviewee quoted above added:

> The government response to all this pressure was to set up a commission to study mental-health services and make recommendations. We were really afraid the report would be filed away. Some of us thought the government was simply trying to take the heat off.

The series of newspaper articles and continued public pressure for improved mental-health services forced the government to act. On November 24, 1967, the Premier, Mr. Manning, accompanied by the Minister of Health, Dr. Ross, announced that the province would conduct a comprehensive mental-health study. The purposes of this study were, first, "to provide an objective, province-wide assessment of resources and evaluation of needs for maintaining mental health and treating mental illness," and second, "to make recommendations for developing an improved comprehensive and integrated program for diagnosis, treatment, care and rehabilitation of the mentally ill and for the prevention of mental illness in Alberta" (Sellar, 1967, p. 1). The study, chaired by W. R. Blair, head of psychology at the University of Calgary, would take a year to complete, and the various stakeholder groups in the province were invited to participate. The importance of this event to all Albertans was demonstrated by the decision to have the Premier announce the study. The choice of a psychologist rather than a psychiatrist to head the study was perhaps indicative of the government's willingness to consider alternative rather than traditional solutions to the problems.

In the June 22, 1968, edition of The Edmonton Journal an article noted that 108 briefs and letters had been received, with 200 more to come. Nine consultants from the United States, the United Kingdom, and eastern Canada had visited Alberta and were to submit reports. In addition, public hearings were conducted at five locations throughout the province, and public seminars were planned in which the recommendations of the report were to be discussed. In a comment that could be viewed as a positive note about the Ponoka hospital, the author of the above article noted that "10 of the briefs submitted have come from Alberta Hospital at Ponoka, professional groups or individuals. The Alberta Hospital Edmonton is represented so far by one brief and the Alberta Hospital, Claresholm, by one" ("Mental Health Briefs," p. 1).

Those interviewed for this investigation recalled that staff had mixed reactions to the Blair study. Nine said they had strongly supported the need for the study and saw it as an opportunity to improve programs and patient care at the hospital. Mrs. Y. recalled: "Dr. Phillips was really enthused about the study. I worked with him and D.E. on a brief. We presented it in Red Deer, and it was really well received."

Mr. G. observed:

> We were trying to get programs going during the sixties. It seems to me most people were anxious to move ahead, yet we still had very few staff, and the ward structure with the large day rooms certainly didn't lend itself to group therapy.

> Really, we had to cope with the architecture of another era, with dormitories that housed 100 to 200 patients. We started to use the attics of several of the buildings, converted them into group therapy rooms. It really worked quite well.

This point of view supported a corresponding observation by Mr. R.:

> The people were ambitious at the hospital. Dorothy and Dr. Phillips spearheaded the drive to get more and better treatment programs, but the lack of facilities and few personnel made our task impossible. We saw the Blair study as an opportunity to make our feelings known. I really believe government officials saw mental-health services as a necessary evil; officially, they had to support us, but in reality there was never any money.

One interviewee, Mrs. A., commented:

> We thought we might be listened to with Blair. We had sent many briefs to the government asking for funding. One I remember was a request for drapes or blinds for the sleeping area on Male 11. The windows were completely uncovered. Dr. Byers supported us in our request.

One interviewee stated:

> I remember that Ted James [Chief of Psychiatric Nursing] was the first to alert us that the study was being done. We got together as a group to hammer out a document to present in Red Deer. One of the things I remember is that Ted really wanted a therapeutic pool for the patients, and it makes me feel so good that we finally have one.

Four of those interviewed saw the study as an attempt by the government to "downgrade mental health." The staff member who made the above comment echoed this view: "If they were really intent on improving mental-health services, why did they discharge all those patients into the community without developing adequate community services? Most of the budget today is still spent on the institutions; that tells the real story, doesn't it?"

Mrs. F., still working at the time of the interview but due to retire in two years, expressed her concerns: "I could see the possibility of improving conditions for the mentally ill, yet I was really afraid for my job, and so were a lot of other staff members." The development of psychiatric units in general hospitals was viewed as a threat by Mrs. G.:

> We were afraid they would admit all the patients. We needn't have worried, because the really ill patients still came up here. I can't remember our admission rate really going down for a long time. The general hospitals certainly didn't want to look after our long-term patients. It seemed to me they only wanted the ones who would respond.

Ten of those interviewed had participated in some way in the study, and six had actually helped to write a brief, while three remarked that they were asked for "input at the ward level." Another person could not recall "exactly" what her participation had been but remembered having had some input.

Three of those interviewed remarked that they could recall specific points in the brief that they had made; two mentioned a pressing need for an increase in staffing, and three stressed the need for more educational opportunities. Mrs. S. stated:

> It seemed to me we did in fact have more educational opportunities. More people started to go to group therapy workshops, and several people went to Banff for groups. Mind you, we paid our own way, but if I recall correctly, the hospital did give us the time off.

Shortly after initiation of the study was announced, a particularly damaging story appeared in The Canadian, a supplement to The Edmonton Journal, on February 23, 1968. A journalist, Tori Salter, posing as a "schizophrenic," had arranged to be admitted as a patient to Alberta Hospital Oliver. "Five Days of Degradation," her graphic description of the overcrowded conditions, demoralizing routines, lack of privacy, insufficient activity, institutional clothing, and uncaring attitudes of staff, culminated in the pained observation and question: "During my five days in hospital, every one of my senses had been bruised and battered, yet I had entered the hospital in reasonably good health. What must such a battering do to the sick?" (p. 11). This article, although it described conditions at the Edmonton hospital, was, in the view of many staff members, just as damaging to Ponoka's reputation. This feeling on the part of the staff was expressed by Mrs. L: "All the public saw was 'mental hospital.' People didn't know there were two mental hospitals. In the view of the public all mental hospitals were the same."

Pressure on the government continued, and the opposition leader, Mr. Peter Lougheed, requested a tour of Alberta Hospital Edmonton (Bell, 1968, p. 1). Through the newspapers, the staff at the hospital indicated that the M.L.A.s would not see "a true picture . . . as the hospital was in the midst of a spit and polish campaign" ("MLA's," 1968, p. 14).

The Ombudsman planned an investigation of "alleged mistreatment and brutality toward at least one patient" at the Alberta Hospital Edmonton ("Ombudsman," 1968, p. 1). The criticism of a member of the opposition, Dr. Hugh Horner, received headlines in The Edmonton Journal when he quoted the view of a British publication charging that "gigantic hospitals are a gigantic evil" ("Big Hospital's," 1968, p. 12).

In what would appear to be a curious response to all this negative publicity, the government announced that it would seek to have the Alberta Hospitals at Oliver and Ponoka accredited ("Accreditation," 1968, p. 21). As the move to accreditation would have resulted in a survey of the hospital by people outside the system, utilizing the accepted standards from the Accrediting Council, the government was risking a further expose of conditions in the mental hospitals.

The improper incarceration of a patient for 22 years at the Ponoka Hospital appeared in a headline, "Sane man forcibly held 22 years, says Ombudsman" (1969, p. 1). The writer noted the man's attempts to have his case reviewed, the blocking of his efforts by officials in the Attorney-General's Department, and the assessment of the Medical Superintendent that the man should not be in a mental institution. The Ombudsman's recommendation that the man "should be released, immediately, unconditionally, and with compensation" was carried out (p. 4). This incident, widely reported in the newspapers, again alerted the public to the need for reform of the mental-health system.

In a strongly worded statement, The Edmonton Journal informed the public that the situation involved "the denial, for an extended period of time, of the liberty of a human being, even though every reasonable indication was that he should be freed." The writer declared that the man was "the prisoner of a bureaucratic, red-tape society, and we can only wonder . . . are there others?" In addition, the response of the Attorney-General to questions in the legislature was viewed as "unsatisfactory" ("The Sane," 1969, p. 4).

Further disclosure of problems within the mental-health hospital system accompanied a "leak" of a brief prepared by the staff at Alberta Hospital Edmonton to The Edmonton Journal's reporter, Karen Harding. Harding, whose series of articles on the problems in the mental-health system did much to stimulate the climate of public opinion which led to the Blair study, was viewed as an ally in the staff's attempts to bring about change. This damaging brief, reported in the March 24, 1969, issue of The Edmonton Journal ("Mental Hospital Staff"), was prepared by the senior staff at Alberta Hospital Edmonton and presented to the Medical Superintendent. The 28-page report, signed by more than 100 staff members, was seen as necessary in that "normal channels for communication in the past have failed to bring about significant improvement in the deplorable conditions that now exist at the Alberta Hospital Edmonton" (p. 1). Problems identified in the brief included the resignation of 9 of the 11 nursing instructors, the prejudicial attitude on the part of nursing administration toward psychiatric nurses, great inconsistency in the approach of nursing staff to patients, and a noncommunicative attitude on the part of administration to students. Recommendations to improve the situation included "a thorough examination and investigation of all nursing service procedures and processes affecting communications, morale of staff, and nursing care"; "senior administrative staff should spend a part of their time on the wards"; "open forums should be held for all staff levels" (p. 1). It would appear that the staff at this hospital was more concerned with problems within its own institution, which may have accounted for its one brief to the Blair Commission as compared with the 10 received from the Ponoka Hospital.

A series of newspaper articles exposing conditions in the mental hospitals, and pressure from various community groups, particularly the Canadian Mental Health Association, and from the public forced the government to respond. The Blair study began a series of events which led to deinstitutionalization of the Ponoka Hospital, and many patients were discharged into the community. The mental-health system was clearly under siege; the public and influential interest groups were demanding change. The next section of this chapter focuses on the Medical Superintendent's perspective on events during this period.

The Medical Superintendent's perspective. Having arrived at the hospital in 1939, fresh out of medical school, Dr. J. M. Byers assumed increasing administrative responsibilities within the hospital, culminating in his appointment to the position of Medical Superintendent in 1965. He is described by Roberts (1973) as having "a quiet but forceful personality" (p. 213). Reports from staff indicated that he was a "good administrator" who was "trusted" and "respected" for his personal integrity. During the years 1967-1971 Dr. Byers was instrumental in discharging many patients. This is reflected in the changes in the hospital's patient population, which went from a year-end total of 960 in 1967 to 641 in 1971.

Further changes in the patient population suggested a dramatic shift in policy. At the beginning of 1967 there were 1,029 patients in residence, and at year-end, 960, a decrease of 69 patients. In addition, the hospital admitted 1,241 patients, a decrease of 281 from the previous year, and discharged 1,280 (Byers, p. 121). It would appear that by 1971 the hospital was actively pursuing a "discharge policy" for both newly admitted and long-term patients.

A comparison of excerpts from the annual reports of the Medical Superintendent for 1967, 1968, and 1969 documents the changes taking place in the hospital in the development of group therapy as a treatment modality:

> The use of group therapy as a means of treatment was expanded. Individual psychotherapy, electroshock treatment and drugs were used quite extensively. (Byers, 1967, p. 121)

> There was an increase in the use of group psychotherapy. Chemotherapy and Electroconvulsive therapy treatment showed no appreciable change. (Byers, 1968, p. 121)
>
> Group psychotherapy was used extensively during 1969. In many instances members of the patient's family were involved in the group sessions. (Byers, 1969, p. 104)

The increasing use of group therapy and involvement of members of the patient's family in the recovery process represented major changes in the thinking of hospital personnel. Many who had focused almost exclusively on the "identified" patient found themselves, in effect, deeply involved in "family therapy," and many family members went to a considerable amount of trouble and expense to take time off work and travel great distances to attend the sessions.

A point worth noting in the 1969 report is the absence of any reference to chemotherapy and the use of electroconvulsive therapy. The use of chemotherapy in the treatment of psychiatric illness was a fact of life not meriting special attention. As hospital personnel became more involved with group therapy, there was correspondingly less reliance on intrusive physical therapies such as E.C.T.

Further development of a broader spectrum of clinical treatments is seen in the 1970 annual report of Dr. Byers: "Group psychotherapy and psychotropic drugs were used extensively in 1970. In addition, individual psychotherapy, behavioral therapy, and electroconvulsive treatment were given. In many instances, members of the patients' families were involved in therapy sessions" (p. 108).

In the above report, group therapy and the use of psychotropic drugs were given equal emphasis, and behavioral therapy was mentioned for the first time. The extent of the use of this new form of treatment could not, however, be determined from examination of documents available at the hospital.

A comparison of the annual reports for the years 1967 and 1968 revealed a new major heading, "Out-Patient Services" in 1968. "One member of the medical staff reserved one afternoon a week for out-patient consultation" (Byers, 1968, p. 121). Dr. Byers estimated that the medical staff saw 300 patients during the year on an out-patient basis and made 440 contacts with community social agencies. In addition to the hospital's beginning to reach out and develop services in the community, as was noted by the Medical Superintendent, a new agency had been formed in Calgary, the "Inter Agency Council of After-Care." People in the agency met monthly with the discharge program staff at Alberta Hospital to acquaint them with the community resources available for the discharged patients in Calgary. By 1969 all members of the medical staff were involved in out-patient consultations and some 250 patients were seen on this basis. In 1970 the number of out-patients increased to 303.

During the period 1967 to 1970 the role of the medical staff gradually evolved from an exclusively in-hospital practice to a hospital and limited-community-focus practice. This change in emphasis also was reflected in the growth of the Social Services Department from six workers in 1967 to nine in 1970. Increasing numbers of patients were discharged through this department to foster homes, nursing homes, and half-way houses. Most were discharged to Calgary, but placements were spread throughout the province. In 1967, 51 patients went to foster homes in Calgary and 53 to nursing homes; by 1968 this had increased to 178 patients; in 1969 there were 473 placements, and in 1970, 357 patients were discharged. Many of these patients were followed up by the social workers in Calgary.

The important role of volunteers was recognized in the Medical Superintendent's report of 1967. Mention was made of the opening of the Apparel Shop by the Women's Auxiliary and the provision of social activities for patients by that group of volunteers. The sponsoring of bus trips by the Canadian Mental Health Association to facilitate visits by friends and relatives, and a Christmas party co-sponsored by the hospital and the Canadian Mental Health Association were also noted. This emphasis was not, however, followed up in subsequent annual reports.

During this period, a continuing theme in the annual reports of the Medical Superintendent was ongoing difficulties in recruiting medical staff. References to the problem in three successive years indicate its persistence:

> One of the major problems has been the recruitment and retention of professional staff. It appears particularly difficult to recruit physicians who are willing to make a career of mental hospital work. (Byers, 1968, p. 123)
>
> One of the major problems continued to be the recruitment and retention of professional staff, particularly medical staff. (Byers, 1969, p. 106)
>
> A continuing problem was the recruitment of medical staff. (Byers, 1970, p. 111)

Dr. Byers did not refer to the Blair study in any reports during this period, but some inkling of the pressures on the hospital was indicated when, in 1968, he wrote: "The difficulty in filling professional positions and a general feeling of uncertainty as to the future role of the hospital tended to lower the morale of the staff but patient morale appeared satisfactory" (p. 123).

The changes the hospital was undergoing were reflected in the annual reports of the Medical Superintendent. There was a reduction in the total patient population from 960 in 1967 to 641 in 1971. The number of discharges was also increased during these years. The emphasis on clinical treatment was illustrated by the increased utilization of group therapy and decreased emphasis on electroconvulsive therapy. Of particular interest for purposes of this study is the absence of any mention of the Blair Report, although Dr. Byers did allude to the decreased morale of the staff as a result of the uncertain future of the hospital.

Response to publication of the Blair Report. The Alberta Mental Health Study, tabled in the legislature on April 11, 1969, received wide coverage in the major newspapers of the day. Harding (1969a) supported the "13 top priority proposals" and "189 over-all recommendations," noting that they were based on "the philosophy that there is no basic difference between the mentally and physically ill. This distinction is outmoded and unfair." Calling the mentally ill "the forgotten citizens of the province," Harding claimed that "the bureaucracy is serving itself, not the patients it is intended to serve. In doing so it has perpetuated '19th century thinking' in the mental health field" (p. 11).

Dr. Blair (1969) concluded his report with 189 recommendations designed to improve the mental-health system in this province. In addition, 13 priorities were identified as needing action at once. Of particular interest to this study were the comments and recommendations that affected the mental hospitals, particularly the Alberta Hospital Ponoka. The following general comment summarized the committee's findings:

> Bearing in mind the three principal limitations affecting this institution (Remoteness of administrative control, geographical isolation from principal communities served, and serious staff shortages), the committee was impressed by the standard of patient care.
>
> In addition, high levels of morale and dedication were encountered in all staff categories. These conditions were not restricted to immediate aspects of patient care. They extended into a concern to remain abreast of the changes in the management and treatment of mental illness through in-service education, undertaken locally.
>
> The committee concluded that, given sufficient support, this institution was strong enough to markedly upgrade the level of patient care and to deal with such lasting problems as its distance from the areas it serves and the consequent need to develop a new role beyond that of a regional mental hospital. (Blair, 1969, p. 34)

A summary of the findings from all of the hospitals surveyed found, however, "an inappropriate administrative system which is so strongly centralized that it could not respond to local problems even with an adequate budget." The committee also noted that "the large patient population in governmental institutions are undergoing treatment with drugs." And, finally, "in no government institution did the Committee find adequate numbers of sufficiently well trained personnel in any category to carry on a reasonable therapeutic program" (Blair, 1969, p. 36).

The study indicated that the mental-health system in the Province of Alberta was organized in a manner reminiscent of an earlier era. There were strong central administrative control, inadequate funding, overcrowding of facilities, inadequately prepared staff, lack of community facilities, and a delivery system which incarcerated individuals far from their communities. Among the many recommendations that would affect the hospital at Ponoka were:

> As a first priority, current suffocating pressures must be taken off the "active treatment" government hospitals, notably the Alberta Hospital, Oliver. Toward that end, it is recommended that:

> a. Admission practices be changed at once to ensure that all illness which can be treated within a general hospital receive attention there and not be allowed to become a responsibility of a mental hospital.
> b. Drug and alcohol withdrawal and detoxification be carried out in general hospitals as a widely enforced rule. Referral of acute alcoholics, in particular, to mental hospitals should stop.
> c. A concerted effort be made to reduce the present populations of mental hospitals as other more appropriate community facilities are created or developed.
> d. Staff shortages be regarded by the Government as having passed a critical point. In the interest of meeting a critical need for improved patient care it is urged that energetic and sustained recruiting efforts be undertaken to build adequate staffs and to maintain them. (Blair, 1969, p. 37)

The committee recommended "the introduction of a new mental health organization and administrative structure," improvement of "the standard of general medical care in the mental hospitals," the development of facilities for the elderly who were confused, the development of educational facilities which were "the responsibility of the Department of Education," and involvement of the Department of Youth and Recreation and the Department of Education in an effort to "improve upon present unsatisfactory services" (Blair, 1969, p. 37).

Four echelons of care were recommended to begin where preventive efforts had failed. The first involved early detection and diagnosis through the school system, guidance clinics, family physicians, and other community agencies; the second, short-term active treatment in general hospitals; the third, longer-term care in auxiliary hospitals and regional mental hospitals; and the fourth, the development of high-quality long-term care in facilities such as nursing homes, boarding homes, and special homes (Blair, 1969, p. 42). If implemented, these recommendations would dramatically change the role of the mental hospital at Ponoka. The committee acknowledged that the mental hospitals could "serve as good regional facilities; they are still highly essential in any delivery system; the only task is to integrate them into a new system" (p. 47). The report recommended that psychiatric units in general hospitals become the primary hospital facility. This would involve the addition of psychiatric wings or units to the existing general hospitals.

Of particular concern to the committee members was a proposal to build a community mental-health center in Calgary. References were made to this proposal several times in the report, and the Commission's stand on this was stated clearly in the final recommendation: "The Province of Alberta should not plan on building any more mental hospitals now or in the foreseeable future. The two large mental hospitals should be reduced to manageable size, while more appropriate facilities are provided in general hospitals" (Blair, 1969, p. 321).

In summary, the report outlined five priorities: (1) the decentralization of mental-health services to be accompanied by the downsizing of the mental hospitals and the development of psychiatric units in general hospitals, (2) the development of a new delivery system in which a new organization and administrative structure would facilitate the development of community mental-health facilities, (3) the active recruitment of mental-health professionals and the transfer of nursing education programs to the Department of Education, (4) improved treatment and facilities for neurologically handicapped people; and (5) an expanded mental-health research program.

The following day (April 12, 1969) The Edmonton Journal devoted two full pages to the Blair Report. Headlines were "Alberta has 'serious lack of research'" (p. 20); "Specialists must be attracted" (p. 19);

"New management structure urged; health branch hit" (p. 20); "Alberta mental hospitals crowded, ill organized" (p. 18); "Province may act on mental study this year" (p. 1); "I'm sure government will act - Dr. Blair" (p. 20).

The Red Deer Advocate reprinted The Edmonton Journal's coverage of the Blair Report. The editor, not as enthusiastic about the report as the Edmonton paper, asserted that Premier Harry Strom had taken "the steam out of the Blair Report with his enthusiastic endorsement of it." It was further pointed out that Dr. Blair and the Canadian Mental Health Association shared the same belief that mental illness "is just like any other illness." The writer disagreed with this premise, insisting "mental illnesses have their own striking characteristics and their own specialized modes of treatment." In his view, the shortage of psychiatrists and psychiatric nurses, along with the acute shortage of beds in auxiliary hospitals and nursing homes, would affect development of the proposed community services "for a long time" ("Blair Report," 1969, p. 1).

The recommendations of the Blair Report were not printed in The Ponoka Herald. The fact that the local newspaper chose to ignore the report and its recommendations was perhaps indicative of the far-reaching effect implementation of the recommendations contained in the report would have had on the hospital and the future of the town.

The Ponoka Herald publicized a meeting to which residents of the area were invited to hear about the report from Dr. Blair. In an effort to allay fears, the writer stressed that "the Blair Report says the imperfections are not due to the staff's lack of concern. Many people have tried to make improvements within the existing system." It mentioned the "remarkable, active and effective patient council at Ponoka, a sheltered workshop (Opportunity Enterprises) on a paying basis after one year of operation in Ponoka (sponsored by patients and local businessmen)" ("Blair Commission," 1969, p. 1). The number of people attending this meeting could not be determined, as there was no further mention of it in later editions of The Ponoka Herald.

Pressure on the government to implement the recommendations of the Blair Report continued with Harding, who had earlier alerted the public to the problems within the mental-health system, expressing her frustration at the lack of action from the government. In an editorial in the family section of The Edmonton Journal, she pointed out that "one would think that now that such a major study ($70,000) has been completed, no further study should be undertaken. What is needed now is action" (Harding, 1969b, p. 22). Since the government had received the report on February 20 and had tabled it in the legislature on April 11, sufficient time had been provided for study and the development of a plan of action. Harding urged the public once again to become involved and demand appropriate action from the government.

Some changes were taking place within the system, as evidenced by the opening of a day clinic in Calgary for the treatment of neurotic and psychosomatic problems ("Calgary," 1969, p. 35); the gradual movement of patients from the mental hospitals into nursing homes ("Mental Patients," 1969, p. 1); and the creation of a permanent board "to review cases of mentally-ill persons committed by court order to mental hospitals in Alberta" ("Cabinet," 1969, p. 1).

The 1970 annual meeting of the Canadian Mental Health Association, held in Red Deer, provided an opportunity for the National Director once again to support the implementation of the recommendations of the Blair Report. He emphasized the isolation of mental hospitals from the community and the need for mental-health services to be community based ("Mental Hospitals Must," 1970, p. 3). The following day, in a strongly worded editorial, The Red Deer Advocate described the Mental Health Association as "getting too cocky" and suggested that the association was still suffering from "a cliche it oversold: that mental illness is just like any other illness." The editor believed that the problem was not the institutions, but rather the lack of qualified people to treat mental illness, and that the C.M.H.A. idea of small community hospitals was out of touch with reality ("Oversold," 1970, p. 4).

During this period Dr. Blair continued to have a high profile, speaking to and receiving support for the recommendations in the report from many community groups such as the Alberta Health Association ("Unanimous," 1969, p. 3); the Psychiatric Nurses' Association ("Too Many," 1969, p. 1); the Alberta Association of Social Workers ("Broader," 1970, p. 22); and the Alberta Teachers' Association ("Battle," 1970, p. 1).

In what might be viewed as support for some of the concerns raised in the Blair Report, the Minister of Health admitted that there were "about 600 mentally ill people in the Oliver and Ponoka mental institutions" who were harmless "but have nowhere else to go." He indicated that the government would be happy to "release many chronic but harmless patients either to families, nursing homes or other community institutions." Lamenting the lack of facilities and his conclusion that "nobody is prepared to take responsibility for them," the Health Minister remarked that the government found itself "in the position of trying to drag public opinion along as it begins to implement the Blair recommendations" and urged the community "to accept its responsibilities" (Burgess, 1970, p. 53).

The response of the Ponoka community to the recommendations of the Blair Report was expressed in the headlines "Ponoka Decries Decentralization of Hospitals." In a meeting, organized by the Chamber of Commerce and attended by 400 citizens, the community expressed its concerns to the Minister of Health. In what would appear to be an effort to alleviate some of the anxiety of the townspeople, the Minister endorsed the basic philosophy of the Blair Report but suggested that the government did not agree with all of its recommendations. He assured the crowd that the government was not contemplating closing the Ponoka institution, but said it "would likely be reduced to 300 beds in the next five years." In the opinion of one member of the audience, "Progress in the treatment of mental illness would receive a fatal blow if the Alberta government pursues a policy of decentralizing highly specialized psychiatric training centers" (Gordon, 1970, p. 3).

On the same day a group of Alberta Service Corps volunteer workers, who had spent the summer at Alberta Hospital Ponoka, made the headlines by requesting that the government investigate conditions in Ponoka. According to these volunteers, a lack of funds and staff shortages had "resulted in adverse conditions at the hospital." Among the concerns raised by the volunteers were a lack of qualified psychiatrists and nurses, the treatment of patients--searches and removal of personal belongings--and the lack of privacy ("Hospital," 1970, p. 3).

Both of these articles were replied to in the next edition of The Red Deer Advocate ("Staff," 1970, p. 3). The administrator of the Red

Deer General Hospital, contacted by an Advocate reporter, responded to the Minister's address at Ponoka. He acknowledged that the Red Deer General Hospital had been treating psychiatric and alcoholic patients for several years and cited several obstacles in implementing the recommendations of the Blair Report. These problems included the lack of trained personnel, a lack of specialized psychiatric staff at the hospital, and the large capital expenditures needed to develop rehabilitation and therapeutic programs.

In another response to the brief of the Alberta Service Corps volunteers, the Minister publicly acknowledged that there were problems in the operation of the Ponoka hospital, but, in his view, these problems could not be solved with money. The difficulties lay, he believed, in attracting doctors, nurses, and other hospital personnel "to work and live in a rural area" ("Staff," 1970, p. 3).

In response to the brief of the Alberta Service Corps, the editor of The Ponoka Herald said that "the criticisms leveled at Alberta Hospital Ponoka are ill-founded to say the least." He believed that the motivation for these sensational criticisms was the boosting of paper sales. In addition to dismissing the claims of the Service Corps workers, the Herald urged its readers not to "press the panic button" about the future of the hospital. The editorial writer contended that a pessimistic view would not do any good, while an "optimistic view could well unveil brighter prospects in the ensuing years." In support of this view, it quoted a staff member who had taken a job at the hospital 21 years before and was advised at the time that the job was only temporary, as the future of the hospital was undecided ("Don't," 1970, p. 1). Ponoka's local paper had not printed the recommendations of the

Blair Report. The above was its sole response to the pressures on the hospital and the changes taking place throughout the mental-health system.

Mental-health news continued to be reported through The Red Deer Advocate. The Alberta Women's Week conference speaker urged women to instill healthy attitudes toward mental illness in their children (van Luven, 1970, p. 3); volunteers were needed to participate in programs sponsored by the Red Deer branch of the Canadian Mental Health Association ("Mental Health Group Here," 1970, p. 2); and the Canadian Mental Health Association held a workshop in Red Deer which focused on future changes in mental-health programs ("Mental Health Workshop," 1970, p. 2).

While the Alberta Medical Association was in general agreement with Blair's report, nevertheless, a word of caution was contained in the following reaction: "The members held reservations regarding the phasing in of the recommendations of the report and warned that these steps must be done with great care and intelligence." The physicians were particularly concerned about the recommendations "to encourage psychiatrists and prospective trainees from elsewhere" and "to change the traditional role of the psychiatrist to that of consultant to other professional personnel and to increase incentives for family practice" ("Doctors," 1970, p. 1).

Early in 1971 Dr. Blair resigned his post as Chief Mental Health Advisor to the provincial government so that "he could speak freely, at any time, on mental health issues." While he recognized that "there had been a marked decrease in the population of mental hospitals," he added his opinion that "very little has been done in strengthening non-hospital facilities and personnel." In expressing disappointment "that not more had been done toward implementing the report," Blair conceded that "he might be making 'unnecessary noises' because he did not know the government's plans" ("Doctor Criticizes," 1971, p. 18).

In 1971 the upcoming provincial election ensured that pressure continued on the government to implement the recommendations of the Blair Report. The leader of the opposition, Mr. Lougheed, along with several MLAs, toured the Ponoka hospital on February 4, 1971. This visit, reported in the February 23, 1971, issue of The Ponoka Herald ("Conservatives"), pronounced that the visitors were pleased to find the number of patients in the hospital had been reduced. Despite the conditions of some of the old buildings, they were said to have been impressed with the level of patient care. Mr. Lougheed assured the staff that the hospital would not be phased down or closed in the near future. He did foresee that, with the implementation of the recommendations in the Blair Report, "some procedural changes may be required" (p. 1).

The following week the hospital received officials from the Division of Mental Health. A short report of the visit in The Ponoka Herald informed readers that "meaningful discussions were held between the visiting department officials and senior members of the hospital administration" ("Provincial," 1971, p. 1).

There is a marked contrast in the amount of press coverage given these two visits. The Lougheed visit was reported in detail, meriting a full page of pictures, while department officials received minimal coverage.

Prior to the provincial election, many groups and citizens continued to pressure the government to implement the recommendations of the Blair Report. A concerned citizen wrote to The Edmonton Journal, expressing his concern that "our mental institutions are still large depositories for mental patients where little effective treatment is given" ("Letters to the Journal," 1971, p. 4). Mr. Lougheed attacked the government for its lack of action on the Blair Report ("Action," 1971, p. 17). The opposition challenged the government to implement the 13 priority recommendations of the report and stated that "mental institutions are suffering staff and morale problems because of uncertainty about their future" ("Government," 1971, p. 10). In preparation for the coming election, the Canadian Mental Health Association presented four educational workshops to the M.L.A.s and political candidates. These programs, which were well attended, were designed to outline the Association's concerns about mental-health services and to enlist the candidates' aid in implementing the recommendations of the Blair Report ("Mental Health Concerns," 1971, p. 26).

The Conservatives were swept into power August 31, 1971, obtaining 49 of the 75 seats. At the annual meeting of the Alberta Medical Association, the new Minister of Health and Social Development, Mr. Neil Crawford, announced that the emphasis in health services would be on prevention and rehabilitation. In a later meeting with reporters, he called the province's mental-health program "poor," and, in an attempt at clarification, added, "The facilities are not poor but there are not enough of them" ("Crawford," 1971, p. 16).

The year closed with the retiring president of the Alberta Hospital Association expressing his concern about the inferior quality of patient care in mental hospitals as compared to that in general hospitals. Several reasons were given: The mental hospitals were far removed from the hospital mainstream; the isolation of the people that run mental hospitals from those who run other hospitals resulted in "little exchange of ideas or problem-solving methods" (McDonald, 1971, p. 1).

Publication of the Blair study brought to the attention of the citizens of Alberta many problems within the mental-health system. The large mental institutions were reminders of an archaic past in which those unfortunate enough to enter the system received little treatment and were expected to remain there for life. The next section of this chapter presents the staff's perception of the changes which had taken place within the hospital as a result of the Blair study.

Response of the Staff

Interviewees indicated that they received information about the report from reading the daily newspaper and from seeing Dr. Blair on television or hearing him on the radio. There was considerable delay before the ward staff actually received a copy of the report, and Mrs. A. remembered that "this caused considerable anxiety among the staff. We wondered what they were hiding from us." Several mentioned that "the report received a lot of publicity. It put a lot of pressure on the government to improve health care." Mrs. X. perceived some conflict in the messages that staff received: "I believe some of the staff and administration would say one thing publicly and something else privately. Personally, I never heard anything, but there was a lot of grapevine talk. The psychiatrists, I believe, were really threatened by this report. It took away some of their power."

Thirteen interviewees believed that the report was generally well received by the hospital staff and recalled that staff groups were set up to study the report. For Mrs. H.,

> The hospital came out smelling like a rose. We were relieved. Generally, everyone liked the report. It didn't affect our day-to-day jobs for several years. Actually, not until they started to discharge patients. We saw the report as an opportunity to improve mental-health care, or it was an opportunity for hospital staff to become more involved with patients in the community.

The development of the first 12-week discharge program was seen by Mrs. S. as a response to the report and to the concerns of the staff that "the patient wasn't prepared to go into the community, and the community certainly wasn't ready to accept the patient." Mrs. A. expressed some bitterness as she recalled:

> Those of us who fought to have the patients prepared to go into the community were told that we were trying to hang onto the patients to keep our jobs. Really, our day-to-day jobs weren't affected until we started to discharge patients. Then things were better around here because we could spend more time with the remaining patients.

She added:

> Dr. Blair was fairly specific in his report about the role of the hospitals at Oliver and Ponoka. His opinion was that the patient should first of all be treated in his home community, then in the regional hospital, and at the end of the line there was Ponoka and Oliver. We really didn't disagree with that idea, but the general hospitals didn't seem too anxious to have our patients.

According to one interviewee, changes at the hospital were incremental but continuous "for several years after the report came out." In Mrs. M.'s view, "Nurses went from being custodians to becoming therapists, and there was more emphasis on treatment programs in the hospital and discharging patients into the community." The number of patients discharged did increase, as illustrated in the following table (courtesy of Medical Records, Alberta Hospital Ponoka):

Table 6

Number of Patients at the Provincial Mental Hospital, 1967-1971

Year	Population	Change
1967	960	
1968	882	-78
1969	818	-64
1970	693	-125
1971	641	-52
Total		-319

Memories of these changes elicited enthusiasm from those who recalled programs in activities of daily living, the development of personal hygiene groups, the availability of "normal" clothing to patients through the Apparel Shop, medication groups conducted by nurses to help patients understand the importance of taking their medications, patients taken into the community so that they could learn to use the telephone or the bus system in the city, and outings in which patients learned to order meals and handle money. Mrs. S. remembered that "some of the patients were frightened on these outings, and some were resistive. They didn't want to leave, but it didn't take long for them to adjust. The staff also became aware of how institutionalized we had all become."

A happy memory for Mr. S was reflected in this statement as he reminded the researcher:

> You will remember that there were over 100 groups in the hospital at that time. Well, some groups seemed to have more "prestige" than others. The Sunnyside group had permanent group leaders and met daily from 8:30 to 4:00. They prepared meals together, met for therapeutic sessions, and prepared themselves to go back into the community. I rotated through the group as a student, and it was a wonderful experience.

Eight of those interviewed expressed concern about the commitment of the government to implementing the recommendations of the Blair Report. For Mr. Y,

> It was hard for me to really know whether government officials really supported the Blair Report. We didn't have much personal contact with them. The newspaper quotes indicated they did. What they said in private I don't know. I was really sure they did until I got out into the community and saw there was really no commitment to develop community services.

Some staff perceived resistance to the Blair Report in the medical community. Mr. N. observed:

> There was a lot of resistance from the medical community to the report. The doctors wanted centralization, and Blair was pushing regionalization. Some of the resistance from the doctors was based on the fact that Blair was not an M.D. They saw their power being eroded and were screaming loudly.

Another recollection regarding the groups included the following incident reported by Mrs. G.:

> After studying the report, the psychiatric nurses wrote a response that agreed with Blair but also feathered their own nest. They really wanted to expand their role.
>
> There was some controversy about the role of the psychiatric nurse. They wanted to call themselves mental-health workers. There were some strong feelings between the registered nurses and the psychiatric nurses. They felt the registered nurses had never accepted them. To the registered nurse there was only one kind of nurse, a registered nurse. The psychiatric nurses really resented them.

The interviewees agreed that the Blair Report resulted in changes to the Mental Health Act and the development of psychiatric facilities in general hospitals, particularly in Lethbridge and Medicine Hat. In Mrs. F.'s view the changes in the Mental Health Act

> made it more difficult to certify a patient and get him into hospital. We also became more aware of the legal rights of the patients. Sometimes we felt our hands were tied: We couldn't let the geriatric patients out in the winter, yet they said it was illegal to hold them. It was frustrating.

The development of the Regional Mental Health Advisory Committees was mentioned by four interviewees. In the opinion of Mr. H., who had been a member of one of the committees for five years, "They were 'window dressing'; they had absolutely no power and could only make recommendations. We used to meet with the Minister once a year in a social setting; needless to say, these were very innocuous meetings."

Four former staff members did not believe that the government supported the recommendations. Mr. J.'s comments were representative of this group:

> The government said they supported the recommendations of the Blair Report. Why didn't they put their money where their mouth was? Sure, it was great for the patients not to have to live in a mental hospital, but the public was not prepared for their arrival.

For Mr. R., "It was clearly a whitewash job and contributed to the Socreds' losing the next election. We all thought Lougheed was more committed to mental health."

Eight of those interviewed felt that the purpose of the study had been partially achieved. With great enthusiasm, Mrs. S. declared:

> I think Blair still has an effect today. I became a convert to his ideas. Blair promoted the early detection of problems and prevention. Unfortunately, many of those services are still not available today. Many of the medical staff are still pushing for centralization of services.

Coda

Although Dr. Bland was not the Medical Superintendent during the Blair investigation, he was perceived by the staff as a change agent, the person responsible for implementing the recommendations of the Blair Report. The following supplementary information pertaining to Dr. Bland may help to clarify his leadership role as a change agent at the hospital.

Dr. Bland, a graduate of the University of Liverpool, England, and his family arrived in Canada in 1966. Following a one-year practice in general medicine in Flin Flon, Manitoba, he and his family moved to Edmonton in 1967. Dr. Bland entered the University of Alberta psychiatric training program, obtaining his Fellowship in Psychiatry from the Royal College of Physicians (Canada) in 1971 (F.R.C.P.C.).

The hospital had discharged many patients during the years 1967-1971, but it was the arrival of the new Medical Superintendent in 1972 that resulted "in the Blair Report recommendations being implemented." This opinion was expressed by all of the interviewees. Comments included, "When he arrived here, things started to change; people were discharged into the community." "A lot of our patients were institutionalized. Really, they weren't ill; there wasn't any reason they couldn't be in the community." "When Dr. Bland arrived on the scene, it was like a breath of fresh air hit the place. He made an impact; he was young." Dr. Bland wanted to discharge the patients, but he also wanted to develop support services for them in the community. The patient count went from 613 in 1972 to 417 in 1976. These statements supported the staff's view that Dr. Bland was a leader who agreed with the recommendations of the Blair Report. Table 7 (courtesy of Clinical Records. Alberta Hospital Ponoka) illustrates the movement of patients into the community during Dr. Bland's tenure at the hospital. There were, however, pockets of resistance to the ideas of the new Medical Superintendent. Mr. X. recalled that "at first some of the medical staff were nasty to him. They said there was no way they were going to take orders from this young twerp. Well, he was so knowledgeable, most of them were won over."

Table 7

Number of Patients at the Provincial Mental Hospital, 1972-1975

Year	Population	Change
1972	613	
1973	529	-84
1974	461	-68
1975	417	-44
Total		-196

In Mrs. A.'s opinion:

> A lot of the social workers were really resistive. It was a lot of work for them, and they thought it was pie in the sky. Some of the planning for discharge was carried out reluctantly, for they felt they were counsellors.

Some families expressed anxiety. According to Mr. R., "They were concerned about the quality of care the patient would receive elsewhere. They were right, too, because we got back some terrible reports."

A humorous incident brought some laughter from Mrs. S. as she recalled the event:

> There was one patient, he had been in the hospital for years and years. At a conference on our ward Dr. B. asked the patient what he thought about living in the community. Well, the patient replied, "You put me in here, and I'm staying till hell freezes over!"

The following comments from Mrs. G. fairly well encapsulate the staff's feelings about Dr. B.:

> What I liked about him, he really kept up with the difficult patients. He would interview them and change their drugs if necessary. He really took a leadership role in the hospital, and people generally followed him because he was a good leader. He supported good patient care and cared about patients. He talked with the patients' families.

Dr. Bland was described in Ponoka Panorama (Roberts, 1973) as "a very approachable gentleman, who carries on the tradition of his predecessors in that he feels it is most important to maintain good rapport between the Hospital and the Community as a whole" (p. 214). The Medical Superintendent was depicted as being optimistic about the future of the hospital. The writer noted that Dr. Bland believed that the hospital would play a more limited role in providing psychiatric services for the southern half of the province and "a major role in treatment of in-patients in central Alberta, with Community Services expanding fairly rapidly over the next few years" (p. 215).

The role of the hospital in providing psychiatric services to the population in the southern part of the province was clearly changing. It is true that many patients were discharged during Dr. Byers' time as Medical Superintendent. However, it was Dr. Bland who was perceived by the staff as the leader who articulated the change in the mission and role of the hospital. It is interesting to note that during the three years that Dr. Bland was at the hospital, his title was changed from Medical Superintendent to Director of Clinical Services, another indication that the old order was changing in the mental hospital.

Dr. Bland left the hospital in 1975 to become Regional Director (Acting), Edmonton Regional Mental Health Services and Assistant Deputy Minister, Alberta Department of Health, Mental Health Division. At present he and his family reside in Edmonton, where he is Professor and Chairman of the Department of Psychiatry at the University of Alberta.

Summary

During the 1950s the publication of several studies of mental hospitals (Caudill, 1958; Dunham & Weinberg, 1960; Stanton & Swartz, 1954) documented the debilitating and dehumanizing effects of long-term hospitalization. Through the development of therapeutic programs, attempts were made at the Ponoka Hospital to improve the life of the residents. The Medical Superintendent (Dr. J. Byers) failed to provide creative leadership in the implementation of these changes and continued to function strictly as an administrator with a narrow view of potential for improvement in the treatment of mental illness. Leadership in this area was provided by other staff, particularly the Director of Clinical Services, the psychologist, and several of the nursing staff.

The human relations movement of the 1960s and staff participation in this contributed to the further development of humanizing relationships among the staff, and between the patients and the staff. The mission and role of the hospital were thus redefined, moving further away from the custodial role to a more therapeutic one.

In 1967 a series of articles by an Edmonton Journal reporter reviewing the mental-health system in Alberta indicated severe problems. The system was archaic, reminiscent of an earlier era, and suffering from a half century of neglect and public apathy. A lack of communication and rigid centralized control of decision making between the Department of Health and its agencies were identified as major concerns. Staff shortages had passed a critical point, and the Department of Health, because of its poor reputation, was not attracting qualified applicants.

The government response to public pressure resulted in the appointment of Dr. W. R. N. Blair and a committee to study the mental-health system in Alberta. The publication of this report in 1968, with its many recommendations, brought further public response and demand for change.

The two large mental institutions were viewed as anachronisms, and the development of other facilities in general hospitals and nursing homes was indicated. Many of the patients at Ponoka were discharged to the community or to other facilities. With less overcrowding at the hospital, there was a further increase in the development of therapeutic programs.

The public documents (annual reports) of the Medical Superintendent did not refer to the Blair study. Implications of the results of this study were indicated in the difficulties noted in recruiting staff and the general air of uncertainty at the hospital. During these years the hospital went from a patient population of 960 in 1967 to 641 in 1971. There are no public announcements that indicated that the leader was providing clear direction in redefining the mission and role of the hospital. Perhaps the Medical Superintendent and the small number of staff found themselves in a position where they did what they could for the patient; yet, in Braceland and Stock's (1966) words:

> just as often, they were made scapegoats and pilloried because of the deficiencies of their institutions, even though the legislatures had failed to give them the funds needed to care for the patients properly and with dignity. In the minds of many legislators, precedent dictated that mental patients should be treated and cared for as cheaply as possible. (p. 23)

During this critical event outside pressures and forces resulted in the staff becoming confused and worried about the changes taking place around them. With the appointment of a new Medical Superintendent in 1972, the mission and role of the hospital were redefined, and, for the most part, staff members became active participants in this process.

Chapter 8

Discussion and Interpretation

The overall purpose of this investigation was to examine adaptive social processes within a psychiatric institution, with special emphasis on and attention to the role of the leader in the change process. To accomplish this task, selected critical events or key turning points in the life of the organization were examined. The roles of the institutional leaders in addressing these critical events were assessed in terms of the unfolding of events and the resolution of issues. This chapter explores the results of analyzing the data and the application of Selznick's (1957) theoretical perspective in analyzing and interpreting the findings. The three major headings identified in Selznick's conceptual framework--the external environment, the internal environment, and leader functions--comprise the framework for this chapter.

The External Environment

To survive, organizational leaders must pay attention to the external social environment in which they operate. Among the factors identified by Selznick (1957) as important for the leader to be aware of are the social environment, the external infusion with value as the organization meets community needs, the coöptation of interest groups, and the nature of potential clients.

Social environment. Selznick (1957) recognized the need to acknowledge the historical development of the organization and to examine the social environment in which it operates. Selznick differentiated between the terms organization and institution. An organization is, in Selznick's view, "an expendable tool, a rational instrument engineered to do a job" (p. 5). To survive, the organization must become an "institution," which Selznick described as "more nearly a natural product of social needs and pressures--a responsive, adaptive organism" (p. 5). Emphasizing the need to look beyond the technical aspects of organizations, Selznick stated that institutional studies must recognize the historical development of the organization and the social environment in which development took place, the centers of power in the community, the community needs which the institution fulfills, and the social class from which its leadership is selected.

With the introduction of tranquilizers, society began to question the role of the mental hospital. Changes in the behavior of patients made it possible for increasing numbers of them to return to their home communities. Pressure was exerted internally and externally to move the hospital from its former custodial approach to a more therapeutic, humanistic approach. Many staff responded positively, and in spite of obstacles, group therapy developed as a major treatment modality. Some staff members, however, continued in their custodial mind-set and roles for many years.

The world-wide deinstitutionalization movement was late in coming to Alberta. Many patients were returned to the community during this period, and there was a formidable degree of public pressure to close mental hospitals. In Alberta, the Blair report provided the impetus necessary for "downsizing" the large mental hospitals and the move toward the development of community mental-health services. The hospital and its historical evolution reflected the changing beliefs and expectations of the larger community it served. The public in the external social environment demanded that the institution change. As Selznick (1957) pointed out, to survive, the institution must change its "aims and capabilities" (p. 5) and must overcome difficulties with groups on which it is dependent. Over the years, the hospital became increasingly aware of its dependence for survival on outside community groups. As it began to be perceived by the public as an anachronism, difficulties occurred in the retention and recruitment of personnel. This was particularly true of psychiatrists, who tended to practice in the larger cities, although there were shortages in staff in all the professional groups.

External infusion with value. As organizations evolve they acquire a unique and distinctive history. They may become valued for "themselves"; they acquire a distinctive identity which in many ways reflects the aspirations of the community. This process Selznick (1957) called institutionalization. To institutionalize, according to Selznick, is to "infuse with value beyond the technical requirements of the task at hand" (p. 17).

For Selznick (1957) the real test of infusion with value is "expendability" (p. 18). If in the eyes of the community that it serves an organization simply carries out a technical function, it will quickly be replaced as more efficient technology becomes available. When organizations become institutions, this infusion with value results in a resistance to change. The organization has come to symbolize community values, and resistance to change develops as "people feel a sense of personal loss" (p. 19). The identity of the staff and the identity of the organization become fused so that an attack on either threatens the egoistic self-definition of both. As the Ponoka Hospital played a large role in the economic success of the town, the institution quickly became valued by the staff and townspeople for itself, both for the employment it provided and for the success of local business. Radical changes advocated by the deinstitutionalization movement and reflected in the recommendations of the Blair report greatly affected the viability of the town. These changes were resisted by many of the staff and the townspeople, who exerted political pressure on the government to maintain a role for the hospital. The hospital was forced to adapt to the changing realities and beliefs of the community about the proper care and treatment of the mentally ill. The mission and role of the hospital was radically altered over the years. Despite the discharge of many patients, the number of staff at the hospital remained fairly constant and thus provided a stable economic base for the town. As expressed by Selznick, institutions are "products of interaction and adaptation; they become the receptacles of group idealism; they are less readily expendable" (p. 22). Inasmuch as changes in the hospital affected not only the staff and patients, but also the viability of the town, the institution became, in Selznick's words, "less readily expendable" (p. 22).

Coöptation of interest groups. As institutions change and adapt to external community pressures, it is necessary that they interact with local institutions. This may result in changes in the institution's "leadership, structure or policy" (Selznick, 1949, p. 13). This concept of coöptation was defined by Selznick as "the process of absorbing new elements into the leadership or policy-determining structure of an organization as a means of averting threats to its stability or existence" (p. 13). Coöptation, according to Selznick, may be "formal" (p. 13) or "informal" (p. 14). Formal coöptation may result when "the legitimacy of the authority of a governing group is called into question" (p. 13) or "when the need to invite participation is essentially administrative" (p. 14). Informal coöptation may be "a response to the pressure of specific centers of power within the community" (p. 14).

The hospital at Ponoka relied exclusively on the catchment area for its clientele. It developed a distinctive competence for handling those whom society deemed were no longer able to function in its environs. As Selznick (1957) observed, as institutions specialize and gain in ability to deal with a distinctive clientele, they also lose flexibility. Not only was the hospital dependent on the community for its patients, but it was also heavily dependent on community support for its survival. When community needs and beliefs changed with regard to treatment of the mentally ill, the viability of the hospital and town was in jeopardy. Throughout these critical events, the town showed little evidence of humanitarian concern and remained primarily preoccupied with the stability of the town's economic base.

The Nature of Potential Clients

The historical development of Alberta Hospital Ponoka, covered in some detail in Chapter 1, illustrates that the hospital was established to meet a particular societal need. The hospital would remove from society those labelled "mentally ill." The site chosen for the hospital, officially because it would provide "an asylum" for these individuals, either inadvertently or by design, conveniently removed the "inmates" from interaction with the mainstream of society. As it was expected that patients would remain for the duration of their lives, treatment emphasized a socialization process in which patients followed the staff's orders and grew increasingly dependent on staff and the hospital. "Good patients," i.e., the compliant, were rewarded with tobacco, trips to town, and off-ward work in the hospital. Thus, the historical development of Alberta Hospital influenced its distinctive competence: the incarceration of the mentally ill.

During times of crisis, usually precipitated by negative publicity, external pressure was exerted on the hospital. For example, the death of a patient in 1928 and subsequent trial of an attendant for manslaughter was widely reported in the newspapers, and the government of the day was under severe public pressure to intervene and improve the situation at Ponoka. The advent of the deinstitutionalization movement in Alberta resulted in critical public debate on the role and function of Alberta Hospital Ponoka. Commenting on negative publicity received by the hospital, some staff expressed dismay over the lack of caring and concern for the mentally ill generally demonstrated by society.

Leaders in Ponoka, particularly the business sector, were distressed at the possibility of the closure of the hospital. The staff at the hospital and, increasingly, the patient population contributed in a significant way to the success of local businesses. The viability of the town was threatened, and business leaders became actively involved politically in promoting the survival of the hospital.

The Internal Environment

A major construct in Selznick's (1957) work is the importance of the internal social environment of organizations. In his view, the human beings who make up the organization necessarily and appropriately attempt to meet their own psychological needs in the course of their work. In meeting their personal needs, members develop an "informal structure" which creates a "great reservoir of energy" (p. 8). Selznick asserted that it is the role of the leaders to harness these "internal social pressures" (p. 8). Thus, Selznick's focus was on the internal workings of the organization rather than on the formal organizational chart. Important ideas discussed under the rubric of internal social environment include internal infusion with value, self-maintenance, adaptability, and organizational character.

Internal infusion with value. In Selznick's (1957) view, organizations embody values rather than create them, and "as this occurs, the organization becomes increasingly institutionalized" (p. 20). As part of this development, institutions, in the view of the members, are "prized not as tools alone but as sources of direct personal gratification and vehicles of group integrity" (p. 40). The organization acquires a distinct identity which colors the nature of its internal strivings and its response to outside pressures.

Throughout the case study the interviewees' responses to the questions indicated that their involvement with the organization was not limited to their "work life." The organization was instrumental in providing outlets for their social and cultural life. In the early days plays were staged at the hospital for the enjoyment of patients and staff. During the 1950s the Ladies' Auxiliary to the hospital, composed of the wives of staff members and a few townspeople, provided "comforts" (gifts of candy, jewelry) to the patients, and the weekly reports in the newspaper kept the community apprised of ongoing events and recorded the changes taking place at the hospital.

Reflection on the wide-ranging interviews revealed two central themes. First, it was clearly important to those interviewed that their stories be told. Every request for an interview was greeted with enthusiasm. Former staff impressed upon the interviewer the difficult conditions under which they worked, the lack of funds, the few personnel, and the constant overcrowding experienced by the patients. Second, as the former staff recalled the names of patients and their interactions with them, the warmth in their voices and their smiles indicated that they cared deeply about their patients and regarded many as close personal friends. Thus, the organization was valued by the staff not just for the employment it provided, but also for meaningful relationships with the people who were part of the social environment.

Self-maintenance. Selznick (1949, 1957) made the point that, as organizations become institutions, the people associated with them develop an emotional investment in the survival of the organization as a "going concern." In achieving this permanence, a balance must be maintained between the internal interest groups who desire this permanence and stability, and the outside pressures on the organization. Leadership, Selznick (1957) declared, was a crucial factor in achieving self-maintenance, and it is important that leaders not become so security conscious or focused on maintaining the viability of the organization that they are "willing to sacrifice quick returns for the sake of stability" (p. 21).

Selznick (1951) argued that there is a close relationship between "infusion with value" and "self-maintenance." He described the organization as a living organism which in the process of institutionalization acquires a "self" and a "distinctive identity" (p. 21). He recognized the struggle "to preserve the uniqueness of the group in the face of new problems and altered circumstances" (p. 21).

Many of those interviewed echoed Selznick's (1957) beliefs. In their conversations they referred to the hospital as a living organism with a "self" and "distinctive identity" in comments such as "our dear old hospital," "I miss the old place," "We were proud of what we had accomplished," "The hospital has undergone many changes and survived," and "This place has mainly been good to me." More than one colleague affectionately, and only half-jokingly, referred to the hospital as "Old Mother A.H.P."

Adaptability. The need for organizations to be adaptable in order to survive was a central focus of Selznick's (1957) model. He recognized that subunits develop in all organizations, and the units strive for security and protection. In the process of developing group integrity, these subunits also develop fixed ways of behaving and thus create organizational rivalry between groups. Selznick maintained that this situation was a particular problem "in a special-purpose enterprise because the aims of the whole are more sharply defined, and therefore more vulnerable to divisive activity, than in the natural community" (p. 9).

In this study it was clear that in the early history of the hospital there was a sharp demarcation between Dr. MacLean's objectives and those of many of the staff. As a physician, Dr. MacLean promoted humane treatment and was opposed to the use of any form of mechanical restraint. Many of the staff had been there during Dr. Cooke's time as Medical Superintendent. They had accepted and implemented the beliefs of Dr. Cooke, that is, that their most important functions were to keep the patient quiet and the physical environment clean. It is a testimony to the force of Dr. MacLean's personality that he was able to turn this situation around.

During the third critical event, almost the reverse was true. Dr. Byers' interests revolved around the details of administrative management, while the staff concentrated its efforts on developing therapeutic programs. In this era the leadership may be seen as emphasizing methods rather than goals, and Selznick (1957) noted that this situation tends to become "a source of disorientation in all organizations" (p. 12). This emphasis in the hospital on administrative management during Dr. Byers' tenure may partially account for the leader's lack of official response to deinstitutionalization. From the beginning it was clear that this movement and the implementation of the recommendations of the Blair study would have a major impact on the delivery of mental-health services throughout the province, particularly on the role and function of Alberta Hospital Ponoka. The pressure experienced by the hospital during this time was alluded to by Dr. Byers in his comments on the difficulties of recruiting and retaining staff.

Throughout his essay Selznick (1957) urged those who study organizations to pay special attention to the social forces, external and internal, which have played a role in its historical development and have resulted in a redefinition of "the role and character of the organization" (p. 12). For Selznick, it was important that these studies "emphasize the adaptive change and evolution of organizational forms and practices" (p. 12).

The evolving historical development at Ponoka indicates an organization which in its early years was focused on the warehousing or incarceration of patients. Restraint for patients was matter-of-factly accepted and widely used by the staff. During the 1930s this began to change slowly under Dr. MacLean's leadership.

By the 1950s the loss of the ability of patients to make decisions for themselves, the loss of freedom, and the antitherapeutic environment created by the large mental hospitals were well documented in many research studies. At Ponoka efforts were made to correct the situation and improve conditions. Therapeutic innovations were initiated through the development of ward associations and groups on the various units. Many patients, for the first time, were given privileges to go to downtown Ponoka.

The evolving, adapting, comparatively sweeping changes were accelerated with the introduction of the tranquilizers. By the late 1960s many patients had been discharged into the community, and the third historical revolution--deinstitutionalization--was well underway. This propelled the organization through a major adaptive process as the number of patients hospitalized was drastically reduced. Questions were raised about the viability of Ponoka as an institution, and the Alberta Mental Health Association conducted a public campaign to close the institution. The townspeople and staff expressed concerns about the mounting pressures and perceived threats in public meetings with government officials. The hospital began exploring alternative roles. There was a noticeable decline in the morale of staff, and many people left the organization. Recruitment of professional staff became increasingly difficult, and the hospital was forced to adapt to these new, often discouraging realities.

Organizational character. In his description of organizational character, Selznick (1957) once again marshalled the personality analysts in fleshing out the concept. Thus, character was viewed as an historical product that is integrated, functional, and dynamic (pp. 38-39). These attributes were drawn on to explain how organizations become institutions. He believed that institutional analysis must include the study of "organizational character-formation" (p. 40). Selznick defined the concept of studying the character of an organization as "the distinctive competence or inadequacy that an organization has acquired" (p. 42). This study, for Selznick, must include an examination which goes "beyond the formal aspects to examine the commitments that have been accepted in the course of adaptation to internal and external pressures" (p. 42).

The developmental character of the Ponoka Hospital was greatly influenced by its early leaders and by the mission and role it had been defined by society. The hospital's first Medical Superintendent, Dr. Cooke, created a strong militaristic, authoritarian atmosphere that permeated every aspect of the staff's and patients' lives. His long tenure, from 1911 to 1931, ensured that his beliefs as to the treatment of the mentally ill were implemented. Dr. Cooke believed that patients were people lacking strong moral principles, and, therefore, the regimen designed by him for their treatment had a strong moralistic bent: Patients must obey orders; they must be taught that they are wrong and that if they do not follow orders, they will be punished. The majority of staff was untrained. They, too, were expected to obey orders, and insubordination resulted in dismissal. A distinct "pecking order" went with the territory, and the junior staff members were among the lowest of the low on the "totem pole," second only to the patients. It is possible to postulate that just as the patients were subjected to the use of mechanical restraints, the staff, in some sense, was also burdened by these devices.

Early Medical Superintendents, Dr. Baragar and Dr. MacLean in particular, attempted to change the custodial character of the organization to a more humanistic orientation. Dr. Baragar remained at the hospital for only a few years. He made an effort to upgrade the quality of care received by the patients through the development of nursing and male-attendant training programs. Dr. MacLean spent many years at the hospital in various capacities, and his influence was evident long after he left the direct employ of the hospital.
Dr. MacLean is remembered for his strong leadership and his efforts to stop the abuse and use of mechanical restraints. Some staff were skeptical of his efforts, but the force of his personality and the respect he engendered among the staff encouraged them to follow his lead. Those who did not comply with his orders quickly found themselves looking for other jobs, and this disquieting fact of life may have prevented any outward signs of rebellion during the difficult 1930s.

The introduction of the tranquilizers during the 1950s did more than anything else to bridge the gap and facilitate communication and interaction between staff and patients. Disruptive behavior decreased to the point where new, creative ideas in therapeutic programming for the patients could be discussed and planned. Many therapeutic groups were formed during this era, and patients were discharged in large numbers back into the community. This resulted in a profound change in the character of the organization. Feelings of confident hopefulness permeated the institution. As members of the staff began to change their attitudes toward the patients, the patients changed their attitudes toward the staff. The hospital adapted to these new, positively charged feelings and began to develop a much less militaristic and more humane social environment.

During the deinstitutionalization phase of its evolution, the character of the hospital was again profoundly affected. Concurrently with the discharge of many patients, some staff began to fear the loss of their jobs. Questions about the viability and appropriateness of the hospital as an institution for treating the mentally ill were raised and publicly debated. The Canadian Mental Health Association pressed for closure of the large provincial hospitals and the treatment of the patient in the community. This had a strong influence on both recruitment and retention of professional staff, and an air of uncertainty pervaded the hospital. Thus, as an institution the hospital began to question its role and mission, and attempts were made to develop new justifications for its continued existence.

Leadership Functions

Selznick (1957) believed that it was important to move away from a focus on leadership activities and to concentrate on the social situations in which leaders function. In his classic essay Leadership in Administration, Selznick concentrated on "identifying and analyzing the chief functions of institutional leadership" (p. 22). He differentiated institutional leadership from administrative management. Administrative management is concerned with the technical functions of the organization, with the development of procedures and policies. A smooth-running, efficient machine is the goal of the administrative manager. On the other hand, Selznick declared that the institutional leader "is primarily an expert in the promotion and protection of values" (p. 28). One of the chief functions of the leader is to define the institution's mission and role. To accomplish this task the leader must have the ability to assess the capabilities of the organization and to utilize this knowledge to "specify and recast the general aims of his organization so as to adapt them without serious corruption, to the requirements of institutional survival" (p. 66). Secondly, the institutional leader is concerned with "the institutional embodiment of purpose" (p. 90) and is invested with responsibility for "shaping the 'character' of the organization" (p. 63). Thirdly, the leader is concerned with "the defense of institutional integrity" (p. 63) through maintaining the values and preserving the distinctive identity of the institution. Finally, the institutional leader is responsible for "the ordering of internal conflict" (p. 63). In this role, the leader is called upon to maintain the balance of power among elite groups in the organization so that "the fulfillment of key commitments will be maintained" (p. 64). The social situation in which leaders operate affects the kinds of work and activities in which they engage.

Leaders at the hospital, particularly the Medical Superintendents, tended to reflect the beliefs of society about the care and treatment of the mentally ill. During Dr. Cooke's era, society, in general, believed that the mentally ill were morally weak. Some remnants of earlier thinking about mental illness as "possession by evil spirits" were also evident. In Alberta there was strong support for the belief that mental illness was hereditary. These beliefs, supported by Dr. Cooke and expressed through his strong personality, created an organization in which these views predominated. Treatment was based on the conviction that patients basically were in need of discipline. An infraction of the rules resulted in the loss of the few "privileges" that were available to patients. The use of purgatives was prevalent. Dr. Cooke may be viewed as a successful leader in Selznick's (1957) terms, for the goals of the hospital were very clear, as were his priorities. The hospital "turned in" on itself and became distinctively competent to perform the task of removing the mentally ill from society. In accomplishing this task through involution and isolation, the leader failed to respond to environmental pressures--particularly the demands of the public following an incident involving the death of the patient. The organizational character had assumed a rigidity that made it difficult to respond and adapt to the changing needs of society. Selznick pointed out that an organization's "true commitments" must be "reassessed continuously" (p. 73). This Dr. Cooke failed to do, due to a rigid insularity, and the organization was set on a path by which it failed to respond and therefore to adapt to changing environmental pressures and expectations.

Although Dr. MacLean did not become the official leader, the Medical Superintendent, until 1936, his beliefs about the use of mechanical restraints were well known and respected by the staff, and he used his influence to work toward the abolition of restraints. His leadership qualities provided the hospital and the staff with the opportunity to respond to different expectations and values. The organization was called upon and inspired to adapt to a more humanistic philosophy. Dr. MacLean assessed the capabilities of the organization and set about to redefine its mission and role. The former custodial, authoritarian orientation of the staff began to change to a more humanistic and therapeutic approach. Dr. MacLean was successful in managing the conflict between those staff members who wished to continue in "the old ways" and those who supported his views. The policy created by Dr. MacLean, which supported the elimination of mechanical restraints, became an important part of the social structure of the organization. The character of the organization was dramatically redefined as it adapted to these new expectations.

During the 1950s the introduction of the tranquilizers at the hospital was accomplished relatively smoothly through the influence of Dr. MacLean. According to all reports, the Medical Superintendent of that time, Dr. Michie, for reasons unspecified, was not instrumental in initiating this change. Although Dr. MacLean had officially left the hospital and was now the Director of the Division of Mental Health, he maintained his office in Ponoka. In that capacity he played a significant role in introducing this epochal change. In his annual report of 1954 Dr. Michie chose not to mention the introduction of the tranquilizing drugs or their effects on the patients. Dr. Michie exhibited a high degree of caution and did not publicly acknowledge the use of these new drugs until his annual report of 1957. A review of his annual reports indicates that the institution was indeed changing, slowly but surely. Dr. Michie recorded the greater freedom of the patients in his reference to the increased number who had been granted grounds privileges. The introduction of group therapy was another major change in the treatment of patients which was supported by the leader. Dr. Michie's skill as an administrator was evident in his annual reports to the government. Although he exhibited caution in his response to the introduction of the tranquilizers, these annual reports (1954-1957) depicted a leader who kept the government well informed about the gradual changes and adaptations taking place at the hospital.

In Alberta the deinstitutionalization movement had profound effects on the role and function of the large psychiatric institutions. The need for the survival of the hospital as an institution was being questioned by both the public and the government. Pressures were exerted on the hospital to redefine its mission and role and to change its character, better to reflect the changing beliefs of the public about the care and treatment of the mentally ill. The decision of the government, in response to public pressure, to initiate the Blair study was not recognized in any of the annual reports of the Superintendent of the hospital, Dr. Byers. The findings and conclusion of the report were, in turn, officially ignored. During this time there were tremendous external pressures on the organization to change its mission and role, and yet the leader, Dr. Byers, left no official indication of his response to those pressures. Dr. Byers, as indicated by his annual reports, was instrumental in the discharge of many patients. The patient population was 1,029 in 1967 and reduced to 693 in 1971. An out-patient service at the hospital was developed in 1968, and physicians saw approximately 300 patients yearly. During the summer months there were picnics at nearby lakes, and camping and overnight tenting trips. In some sense Dr. Byers may be seen as implementing the main recommendations of the Blair Report before its publication. An after-care clinic was developed in Calgary for the follow-up of discharged patients. In the leader role Dr. Byers was perceived by the staff as focused on routine decision making and maintaining an efficient organization. The focus was on ways and means to achieve efficiency rather than on the creative tasks of leadership, which were to redefine the "basic mission of the enterprise" (Selznick, 1957) and to create "a social organization capable of fulfilling that mission" (p. 136). The organization grew less able to "justify its existence ideologically" (p. 6). This period in the hospital may be characterized as an internally oriented "evolution by involution." Staff members were concerned with the survival of the organization and, consequently, with preservation of their paycheques. The values of society had changed, and the organization had failed to respond adaptively to these changes. The hospital became an anachronism and a symbol for derision in the wider community. "Keep acting like that, and you'll end up in Ponoka" was a popular expression that reflected a common attitude.

Summary

The purpose of this chapter has been to interpret the findings from the three critical events and to apply the Selznick (1957) theoretical perspective in the analysis of the data. The early character of the hospital, with its rigid, hierarchical structure, made it difficult for the organization to respond flexibly, creatively, and adaptively to changing community needs. During the 1950s the introduction of the tranquilizers and the resultant changes in the behaviors of the patients and staff enabled patients to be discharged into the community and had a major impact on the downsizing of the hospital. Hospitalization no longer was seen as a "life sentence," and many patients were being discharged into the community. With the growing emphasis on group therapy, the atmosphere at the hospital became increasingly therapeutic. The institution gradually relinquished its former status as the major center of treatment for the mentally ill in the province. The deinstitutionalization movement and publication of the Blair report accelerated the need for the organization to adapt to changing expectations. Staff members had begun to fear the loss of their jobs, and the town became concerned about its viability if faced with the dismantling of its economic base. In the opinion of the staff it was not until the appointment of Dr. Roger Bland as Medical Superintendent that decisive steps were taken to redefine and reshape the institutional mandate.

The leadership provided by the Medical Superintendents varied from those who were mainly concerned with administrative management and attempting to achieve a smooth-running machine, to those who assumed a more creative, statesmanlike role and fulfilled the four functions of the leader as described by Selznick (1957). The theoretical framework of Philip Selznick facilitated the development of increased understanding of adaptive change and leadership in the psychiatric hospital.

Philip Selznick's (1957) theoretical constructs and perspectives on organizational leadership in the process of change provided the framework and central focus for this thesis. The development of the research questions, the selection of critical events, and the method of inquiry and analyzing the data confirmed the practicality and power of Selznick's ideas.

Selznick's (1957) virtually exclusive focus on the superordinate role of the designated key leader did not lend itself to consideration of the importance of secondary leadership roles of subordinates. During the 1950s the introduction of tranquilizers and the focus of the Medical Superintendent on administrative aspects of the organization transformed nurses from custodial functionaries to therapeutic practitioners.

Selznick (1957) emphasized the need for the institutional leader to become an expert in the "promotion and protection of values" (p. 28). The values that are to be promoted and protected by the leader are, unfortunately, never clearly defined by Selznick.

Chapter 9

Reflections and Conclusions

The concluding chapter of this research comprises three sections. The first contains a brief orientation to the setting for the research, Alberta Hospital Ponoka; the research design; and findings of the study. The conclusions of the study, written in the form of working hypotheses, are included in the second section. The final section focuses on implications for further research and personal reflections on the research process.

The Setting

The central focus of this study has been on the process of adaptive change, with primary emphasis on the role of the leader within a particular psychiatric institution, the Alberta Hospital Ponoka.

Opened in 1911, the hospital was for many years the treatment center for all Albertans who required psychiatric care. It was situated in a rural location, away from the major cities, and patients were far removed from families and friends. Admissions to the hospital increased at a greater rate than funds could be obtained to erect new buildings.

Initially, the hospital was organized with a rigid authoritarian structure, with the Medical Superintendent at the top of the hierarchy and patients at the bottom. The treatment of patients reflected the beliefs that patients came to the hospital for life, were to be kept clean and safe, and were not permitted to escape. Obedience to the many rules and regulations at the hospital was highly valued, and patients who met these standards were given privileges such as tobacco or trips to town. Severe overcrowding, funding inadequacies, shortage of personnel, lack of training for personnel, and prolonged segregation of both patients and staff combined to create an institution in which patients were "warehoused." The hospital carried out its custodial role with great efficiency. It is at this stage in the history of the hospital that the first of the three critical events selected for analysis, the elimination of mechanical restraints (1928-1936), took place. The process of adaptive change in the organization and the role of leadership in the change process form the basis of the research into this event. This focus is carried through in the two additional events under scrutiny in this research, the introduction of the tranquilizers (1953-1957) and deinstitutionalization (1967-1975). This research was guided by a set of research questions which reflected the Selznick perspective and gave direction to the development of the research questions and the design and methodology.

Statement of the Problem

The central purpose of the investigation was to examine adaptive social processes in a psychiatric hospital, with special emphasis on and attention to the role of the leader in the change process. The nature of the questions to be addressed and the importance of understanding the selected critical events from the participants' points of view lent themselves to a naturalistic research paradigm approach.

A series of interactive, informal interviews, partially structured, was held for each of the three critical events. The interview questions served as a guide and permitted the researcher to focus on the multiple realities of the interviewees, their perceptions, and their interpretation of events. Participants were asked to share their perceptions of the hospital and to recall the precipitating factors leading to the implementation of new policies. Finally, each interviewee described the changes which took place in the hospital as a result of this implementation.

In addition to the interviews, government documents, the annual reports of the Medical Superintendents, newspaper articles, and materials available through the hospital museum or the Public Archives of Alberta were scrutinized for information which could clarify, add to, or corroborate data obtained from the interviewees or other sources.

The following questions guided the research process:

1. What were the essential characteristics of selected critical events in the evolution of the hospital?
2. How were the organization's mission and role redefined as a result of important events in its development?
3. How did the organization shift its goals and priorities as a result of internal and external pressure?
4. What were the specific problems encountered as new policies were developed and implemented?
5. What was the leader's role in facilitating the adaptation of the organization to important events in its development?

Research Design

A case-study design using qualitative methodology was considered best suited to the purposes of this investigation. An extensive, in-depth examination of three selected critical events in the life of the hospital was conducted. These events, or key turning points, were significant in redefining the mission and role of the hospital. External forces played a part in the implementation of new policy; and an institutional leader was influential in determining the redefinition of the new hospital role. Three critical events were selected for analysis: the elimination of mechanical restraints (1928-1936), the introduction of tranquilizers (1953-1958), and the deinstitutionalization of the hospital (1967-1975).

The framework for analyzing the data obtained in this study was provided by Selznick (1957), who viewed the organization from a sociological perspective and was concerned with the adaptive social processes of the organization rather than with its instrumental or behavioral characteristics. Thus, for Selznick it was important to understand the internal forces operating within the institution and the external forces impinging from without. The leadership of the organization is a critical factor, in Selznick's view, in the general adaptation of the organization. It is vital, he stressed, for the leader to have a clear vision of the institution's mission and to be able to communicate this vision to the staff. Equally as important, the leader must have the ability to keep the members of "elite" groups within the organization focused on its overall mission and role.

Synopsis of the Study

The research questions focused on the essential characteristics of selected critical events, the redefinition of the organization's mission and role, the external and internal pressures which caused the organization to shift its emphasis, problems encountered as new policies were implemented, and the leader's role in the adaptation process.

These questions serve as a framework for presenting the data from the three critical events.

In the first of the critical events selected for analysis, the elimination of mechanical restraints, the hospital functioned as a small, isolated community with a rigid hierarchical structure. At the apex was the Medical Superintendent, whose orders were carried out by the staff. Junior staff members acquiesced to the more senior staff. At the bottom of this hierarchy were the patients, who were expected to obey orders from the staff. The majority of the patients were involuntarily confined and lived in overcrowded, primitive conditions.

The death of a patient at Ponoka, following an incident with several attendants, received wide publicity in the newspapers. Following the arrest of eight attendants, the subsequent trial, and the incarceration of one attendant for five years, the government appointed Dr. C. M. Hincks and Dr. C. B. Farrar, two prominent Ontario psychiatrists, to conduct an inquiry. The investigators' report documented many problems at Ponoka: overcrowding, lack of staff, poor staff attitudes and training, and excessive use of seclusion and restraint. Interviews with staff revealed that, in the staff's perception, restraints were used very little. The deficiencies of the hospital reported by Hincks and Farrar indicated the need for the hospital to change its mission and role from a custodial to a more therapeutic, humanitarian orientation. As Medical Superintendent from 1916 to 1931, Dr. Cooke established an atmosphere at the hospital which focused on control, obedience, safety, and incarceration. Patients admitted to Ponoka generally received a "life" sentence. Staff interviews indicated that Dr. MacLean, who had arrived at the hospital in 1928, supported the Commissioner's assessment of excessive use of mechanical restraints.

The staff understood that Dr. MacLean was opposed to the use of mechanical restraints; he did not want force used on the patients. The staff who did not agree with Dr. MacLean's view generally remained quiet, as he was held in great respect by the majority of the staff. He did not become Medical Superintendent until 1936, yet his influence and personality clearly set the stage for "officially" stopping the use of mechanical restraints in 1936.

Major problems still remained at Ponoka (overcrowding, lack of staff, inadequate funding), but the hospital was slowly beginning to change its mission and role from its original focus on obedience, custodial care, incarceration, isolation, and safety to a more humanistic, therapeutic environment.

The publication of several studies during the 1950s documented the debilitating effects of large organizations on patients and staff. These studies documented the rigid, hierarchical organization in the hospitals studied and the resulting negative effects on patients and staff. Mental hospitals were generally underfunded, overcrowded, and, for the most part, staffed by untrained people. They became large warehouses which served to keep the mentally ill away from society.

The introduction of tranquilizers opened up the possibilities of discharging patients. Staff and patients were increasingly able to communicate with each other. With the discharge of patients there was some relief in the severe overcrowding of the hospital, and therapeutic programs, particularly group therapy, were developed. As the staff observed the changes in the patients' behavior, they became more "hopeful" and, consequently, were willing to try new programs. The movement of nurses into group therapy changed the role of the nurse from custodian, or keeper of the keys, to therapist. As nurses formed the largest group of staff at the hospital, this opened up many therapeutic possibilities, although many vestiges of the hierarchical system remained.

As late as 1957 only 30% of the patient population at the hospital were receiving the tranquilizing drugs, yet the annual reports of the Medical Superintendent indicated that continuous change in the hospital was taking place. In addition to the community coming to the hospital, patients and staff were now going into the community. Work projects involving the townspeople and local farmers were initiated. Many patients went into town on Saturdays, and some attended the local churches.

Concerns were raised by some staff about the weight gain of the patients on tranquilizers and the side effects of these drugs. Some patients regressed to the point where they needed total care by staff, and many displayed symptoms such as drooling, dry mouth, and tremors. In spite of some difficulties, the general consensus was that the tranquilizers had brought tremendous positive changes to the hospital.

During the introduction of the tranquilizers, the Medical Superintendent, Dr. Michie, displayed great caution in fully endorsing these new drugs. However, his annual reports clearly indicated a hospital undergoing major change. The hospital was discharging patients, and those remaining were receiving more therapeutic programming in a more humane environment. It is a testament to Dr. Michie's skill as a leader that he was able to keep those to whom he reported in the political world fully informed of these changes without raising undue concern on their part.

Early in 1967 the problems within Alberta's mental-health system were described in a series of five articles by The Edmonton Journal reporter Karen Harding. These articles, accompanied by photographs, depicted the two large mental hospitals as overcrowded, underfunded, and understaffed--with a shortage of certified psychiatrists, in particular. The Alberta Division of the Canadian Mental Health Association supported these findings and publicly pressed for reform. Other groups and citizens joined in and, amid mounting public pressure, the government initiated a mental-health study, chaired by Dr. W. R. Blair, Chairman of the Psychology Department at the University of Alberta.

Dr. Blair and his committee were to assess resources and evaluate needs in order to improve present treatment and prevent mental illness in Alberta. Citizens were invited to participate in this process, and as the mental-health study group travelled around the province, it was presented with many briefs from interested citizens and groups. The publication of the Blair Report, as this document came to be called, was to have far-reaching effects on the mental-health system of the province. Dr. Blair recommended a major shift in thinking in the treatment of the mentally ill. Community services were to be developed, and patients were to be treated close to their home community.

If hospitalization was required, psychiatric units in general hospitals close to the patients' home communities were to be developed. If implemented, these recommendations would change the mission and role of the Alberta Hospital Ponoka dramatically. The government publicly committed itself to implementing the recommendations of the Blair study.

The staff at the hospital expressed great concern about the viability of the institution, and many left. Recruitment became a problem and was documented in the annual reports of the Medical Superintendent. There was no official recognition of the Blair study in the annual reports of the Medical Superintendent Dr. J. Byers. Changes in the hospital were clearly taking place. The annual reports of the Medical Superintendent indicated increasing use of group psychotherapy, decreasing use of electroshock, and the development of follow-up services in Calgary for discharged patients. The number of patients in hospital dropped dramatically from 960 in 1967 to 641 in 1971. These changes were effected despite the many admissions to the hospital. There appears to be some indication that, while not publicly recognizing the Blair Report and its potential effects on the hospital, Dr. Byers was in effect implementing the recommendations before they became public knowledge.

Summary of the Findings

1. In examining the character of the hospital from an historical perspective, the first Medical Superintendent, Dr. Cooke, was adamantly clear about the purpose and role of the mental hospital. The organization he envisioned and organized was militaristic, hierarchical, authoritarian, and custodial. The persistence of these beliefs in the organization made it difficult for the organization to adapt to the changing needs and values of society.

2. The original purpose of the hospital was to remove from society those whom it had deemed "mentally ill." For many years the hospital met society's needs in much the style of a "leper colony." Concern was aroused in the community following the death of a patient. This crisis

prompted the community to question the treatment of those who had been sent to the hospital. From this crisis a leader emerged who introduced a more humanitarian, therapeutic approach to the patients. Thus, external pressures and the vision and actions of a leader, Dr. MacLean, combined to inspire and motivate the staff to improve treatment of the mentally ill.

3. Although hampered by lack of funds and inadequate staffing, over the years the organization continued to make incremental changes. It was the introduction of the new tranquilizing drugs that began a movement that was to change forever the role and function of the mental hospital. Up to this point, the number of patients had continued to increase at an alarming rate. Once admitted to a mental hospital, patients expected to die there. The effect of tranquilizing drugs on the patients made it possible to discharge many back to their home community. As the number of discharges increased and admissions decreased, the total number of hospitalized patients declined significantly. As patients became dramatically more manageable, often literally overnight, staff attitudes changed, and more therapeutic programs were introduced for the patients. The leader during this era, Dr. Michie, was reluctant at first to publicly endorse these new drugs, and this was reflected in his failure to document or even refer to this major innovation for three years in his annual reports. It is clear, however, that Dr. Michie supported the changes taking place at the hospital and was keeping officials in the government abreast of the changes taking place at Ponoka so that they would not be caught embarrassingly uninformed if word leaked out.

4. The world-wide movement toward deinstitutionalization reflected in the decision to conduct the Blair study brought to the attention of the public the many problems associated with large, inadequately funded, and poorly staffed institutions. It became clear that the hospital at Ponoka was no longer meeting the needs or expectations of society at large. The institution became an anachronism, a crumbling symbol of another age. The organization had failed to adapt to the changing needs and expectations of society. The response of the hospital to these external pressures was to turn inward upon itself; in effect, to "circle the wagons" in a last-ditch defensive stand. This is clearly reflected in the absence of any reference to the Blair study in Dr. Byers' annual reports. It is interesting to note that, despite his failure to articulate a new mission for the hospital, during Dr. Byers' tenure many patients were discharged. Dr. Byers could be viewed as an administrative manager who was primarily interested in a smooth-running machine rather than an institutional leader who might strive to redefine the role and mission of the hospital so that it would keep pace with community needs. Yet Dr. Byers, through the discharge of many patients, implemented some of the recommendations of the Blair Report before they became public.

5. As the hospital developed its base for potential clients, the mentally ill, it concentrated on developing competence in a narrowly circumscribed sphere: the custodial care of the mentally ill and the unwanted in mainstream society. This competence, however, placed strict limitations on the organization and hampered the ability of the organization to expand its mission to a broader-based role.

6. The process of institutionalization took place both externally and internally. The hospital became "infused with value" for the townspeople as it provided an economic base for the town. If the hospital were closed, the viability of the town would be jeopardized. For the staff at the hospital, the organization met social and psychological needs, over and above providing employment. Attacks on the hospital were viewed as personal threats and as accusations of failure. Staff expressed fondness for patients and the hospital as an organization.

The critical events presented in this research traced the beginnings of an organization which was set up to meet the needs of society at the beginning of the twentieth century. Over the years the hospital did adapt to a considerable extent to the changing needs of society. It was the deinstitutionalization movement that brought clearly into public awareness the problems associated with an organization developed for another age with a different set of values and beliefs.

Working Hypotheses

Several authors (Cronbach, 1975; Lincoln & Guba, 1985) have proposed the use of the term working hypothesis rather than conclusion when working in the naturalistic paradigm. In Cronbach's view, "Generalizations decay. At one time a conclusion describes the existing situation well, at a later time it accounts for rather little variance, and ultimately it is valid only as history" (p. 122). Cronbach recognized the unique factors present in each situation and the counter-productivity of generalizations in the following statement: "When we give proper weight to local conditions, any generalization is a working hypothesis, not a conclusion" (p. 125).

Lincoln and Guba (1985) supported the stand taken by Cronbach (1975) and proposed that "between the poles of the most general (nomothetic) and the most specific (idiographic) is the broad range of the related; we are dealing here with a continuum, the two ends of which do not begin to encompass all the possibilities that exist" (pp. 122-123). Working hypotheses are, for Lincoln and Guba, "tentative both for the situation in which they are first uncovered and for other situations" (p. 124).

The following working hypotheses emanate from the findings of this research and, in keeping with the Selznick perspective, have been organized into five categories: changing mission and role, internal pressures, external pressures, problems encountered, and leadership.

Changing mission and role. The acceptance of the original purpose, mission, and role of an organization by the staff may lead to difficulties in the process of adaptation to changing purposes, missions, and roles. Adaptation becomes more difficult as the direction and movement of the organization come to have lives of their own. Once the original mission and role have been accepted by the leaders and followers, adaptation to a new mission and role may require a new leader and a sufficient number of followers to "tip the balance" to the new leader and role. This was illustrated at Alberta Hospital Ponoka following the Blair (1969) study, which recommended the development of community care and the downsizing of the mental hospital. The arrival of a new leader was perceived by the staff as "tipping the balance" in favor of implementing the concepts proposed in the Blair study.

Internal pressures. In the three critical events selected for analysis--the elimination of mechanical restraints, the introduction of the tranquilizers, and deinstitutionalization--discomfort and dissatisfaction provided the primary impetus for change. There was some commonality to the selected critical events: an awareness that something was wrong and that the old system was inadequate or insufficient. A sense of awareness and growing sensitivity to the perpetuation of suffering, along with a general trend toward more humanitarian treatment, led to the implementation of change. In some cases particular events precede the initiation of change. For example, the introduction of tranquilizers and the resulting changes in the behaviors of the patients and staff provided the new conditions necessary for redefinition of the mission and role of the hospital; formalization of the change followed the critical event. The same principle could be applied to deinstitutionalization.

External pressures. The environment and the philosophical milieu of the day affect the selection of leaders in public organizations. The type of leader selected is determined by the type of societal problems to be solved. The selection of Dr. E. Cooke as Medical Superintendent and his style of management combined with societal beliefs about the need to incarcerate the mentally ill to create an organization characterized by a rigid, hierarchical, authoritarian, and custodial atmosphere that was to last for many years.

The changing of the status quo in an organization is facilitated by critical events (e.g., the introduction of the tranquilizers). External pressures and a different kind of leadership were necessary to redefine the mission and role of the hospital during the deinstitutionalization era.

Influential public factors, the philosophical milieu of the day, and a paradigm shift in beliefs about treatment from the broadest level of society combined to alert the government to the need for change and resulted in the deinstitutionalization movement in Alberta. Governments may move to initiate change because the status quo is no longer perceived as satisfactory by the electorate.

Problems encountered. The initiation of certain events in society such as the introduction of the tranquilizers or deinstitutionalization is first envisioned as an ideal which, though not fully understood, serves as a powerful symbol for mobilizing energies to effect change. Possible problems are initially not anticipated. It is accepted that the ideal is generally applicable; later, it is found that the ideal is applicable in only certain cases.

Leadership. A strong leader who has the ability to convey a clear mission and role for the organization will have a strong influence on the adaptive functions of the organization in meeting changing societal needs and values. A prime mover, a leader, combined with discomfort and dissatisfaction with the status quo, will initiate the process of change and adaptation in an organization.

Leader style has a significant effect on the types of policies conceived and implemented. The force of the leader's personality is a prime motivational factor in moving toward change in an organization. The leader may achieve results through co-operation, coöptation, or intimidation. A charismatic leader who sees things differently from everyone else is necessary for the implementation of successful change.

As the organization changed from a hierarchical, custodial orientation to a more humane, social environment, nurses adapted their custodial role to a more therapeutic role.

Implications for Further Research

This study, conducted in a large psychiatric hospital in central Alberta, investigated the adaptive social processes in the institution, with particular attention to the role of leadership in initiating change. Since this study is confined to one organization and utilizes a particular theoretical perspective, findings will not necessarily be applicable to other organizations. Further research is needed, utilizing this framework, in other organizations with a similar mandate.

The selection of three critical events--the elimination of mechanical restraints (1928-1936), the introduction of the tranquilizers (1953-1957), and deinstitutionalization (1967-1975)--influenced the data-collection procedures and the quality of the data obtained. More work needs to be done on the effects of selecting particular "events" for research and the consequences this may have on the outcome of the research.

Nurses comprise the largest group of staff in any hospital and have tremendous impact on the daily lives of patients. This is particularly true in a psychiatric setting. More research is needed to evaluate change in organizations and the effects of change on nursing practice. In the three critical events examined in this study, it is interesting to note that senior nursing personnel were not seen to be institutional leaders. As the question of nursing leadership was not addressed explicitly, further study might clarify the role of nursing leaders in the hospital.

More in-depth study is needed in the area of interaction between leaders and subordinates which yields insights into the acceptance and implementation of the leader's ideas by subordinates. Studies are needed which illuminate the effects of organizational climate on the interactions of patients and staff. The effects of leader characteristics on the attraction, recruitment, and retention of personnel is an area of study which needs attention.

Longitudinal studies of public institutions such as mental hospitals are needed to clarify the external and internal pressures which result in successful or unsuccessful adaptation of these organizations.

Personal Reflections

Reflecting on the process involved in this thesis, the researcher experienced many emotions and thoughts. Driving home after my interviews with the respondents, I became aware of how many displayed humor in the telling of their stories. Particularly evident was their ability to laugh at themselves, to see the humor in situations that must have at times been very difficult. Many of the interviewees would recall patients, and it became clear that they did not think of the patients as a "medical diagnosis" with a particular set of symptoms, but rather as real people about whom they cared.

Listening to the tapes after the interviews and then having them transcribed was the first step in being true to the meanings expressed by the interviewees. During data analysis I was surprised at how quickly categories began to emerge. The stories were very consistent, although the examples given depended on the area in which the person was working. I experienced some anxiety as I wrote up the events, for I felt a sense of obligation to the participants, and I wanted to reflect accurately their stories and experiences. It was with some relief that I received comments from those participants who read the case studies. Some minor corrections were made in the spelling of names and clarification of dates, but the message received was very clear: "Yes, that's the way I remember it."

I was amazed at how much energy the research process consumed, yet it seemed that I was constantly thinking about my research--in the car driving home, as I was going to sleep, or even on a few embarrassing occasions when someone was talking to me.

The basic question remains, What did I learn from doing this research? At this point this is a very difficult question to answer, as I am sure that personal insights and learning will continue to emerge in the months and years ahead.

There was a sense of exhilaration as pieces of the "kaleidoscope" became clearer, and the Selznick (1957) perspective proved to be facilitative in understanding the data. I developed increased appreciation for the need of the leader to be aware of the forces operating both internally and externally in any organization. Selznick pointed out the importance of a leader having a political orientation in the broadest sense of the word. Examples of the leadership at the hospital failing to be cognizant of changing public opinion are well illustrated in the hospital's response to the worldwide deinstitutionalization movement.

Leadership as a concept continues to fascinate me. My appreciation of the importance of leadership in organizations has deepened, particularly as it relates to the responsibility of the leader to "define the mission" of the organization and to ensure that the organization adapts to changing community needs and expectations. It seems clear that leaders who create rigid, hierarchical, authoritarian institutions, in which staff and patients feel repressed, contribute in a significant way to the deterioration of patients rather than to their rehabilitation. This research has illustrated the need for a particular organization to adapt to changing community expectations. The importance of the role of the leader in adapting the organization to meet these needs has been a continuous theme. It is hoped that this study will help to contribute to the body of literature on mental hospitals as institutions.

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Appendix 1

Access to the Institution

ALBERTA
HOSPITAL
PONOKA
PSYCHIATRIC TREATMENT CENTRE

Our File Reference
Your File Reference

Box 1,000
Ponoka, Alberta, Canada
TOC 2H0
Tel (403) 783-3351

June 30, 1987

Mrs. Mary Abt
Box 522
PONOKA, Alberta
TOC 2H0

Dear Mrs. Abt:

The Mental Health Hospital Board, Ponoka met on June 18, 1987 and approved the commencement of the pilot project for your doctoral candidacy at the University of Alberta.

A steering committee within the Hospital will be available to assist in this regard. This committee will be chaired by Mr. Mark Ewan and will include the Associate Executive Director of Clinical Services.

We look forward to being involved with this project, and would be pleased to make arrangements for any assistance the Hospital can provide.

Yours truly,

Ken Sheehan
Executive Director

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Appendix 2

Interview Questions:

The Elimination of Mechanical Restraints

The Elimination of Mechanical Restraints

The General Atmosphere at the Hospital

- Were you working at the Hospital when mechanical restraints were in use?
- Could you tell me what it was like: the general atmosphere, treatment of the patients, the staff?

Utilization of Restraint

- What kinds of restraints were used?
- How frequently were restraints used?
- On whom were restraints used?
- What were the reasons given for using restraints?
- Who made the decision to use restraints on the patients?

Staff Resolution of the Issue to Stop Using Restraints

- How was the decision made to stop using mechanical restraints?
- Were there any problems or pressures which led to making the decision?
- Who made the decision?
- How was the decision implemented?
- Who supported the decision?
- Were there any dissenters?
- How long did it take to implement the decision?
- What changes resulted?

Community Response

- Was there any reluctance or dissatisfaction in the community with the use of restraints?
- Was the community dissatisfied with the decision to stop using restraints?
- If so, how did they express their opinions?
- Do you have any further comments or reflection on this issue?

Appendix 3

Interview Questions:

The Introduction of Tranquilizers

The Introduction of Tranquilizers

The General Atmosphere at the Hospital

- Were you working at the hospital when the tranquilizers were introduced?
- Could you describe what the hospital was like before the introduction of the tranquilizers: the general atmosphere, treatment of the patients, the staff?

Staff

- How did you hear about these new drugs?
- What was the general staff reaction to the introduction of these new drugs?
- What was your attitude toward them and your initial reaction?
- What information did you receive regarding these new drugs? How was this information communicated?
- Were provisions made for formal orientation or training of staff pertaining to the new drugs? Describe this training.
- What effect did the introduction of these drugs have on the staff?
- How did your work at the hospital change?
- How did the staff respond to the changes in the patients' behavior?
- Did the staff have any concerns about these drugs?
- What were these concerns, and how were they expressed?

Patients

- Who administered these drugs to the patients?
- How were these drugs administered?
- What was communicated to the patients about these new drugs?
- What effect did the drugs have on the patients' functioning? Could you give me specific examples?
- Did the drugs have any effect on how the patients responded to each other and to the staff? Specific examples?

Drugs

- Who made the decision to administer these drugs to specific patients?
- What kinds of control and regulations were put into effect?
- How was the dosage determined for a given patient?

Hospital

- Were there particular individuals in the hospital that you remember as being primarily responsible for the use of these drugs?
- Who was involved, and how was this done?
- Describe the effect these drugs had on the overall hospital atmosphere.
- What effect did the introduction of these drugs have on the community's perception of the hospital?

Appendix 4

Interview Questions:

Deinstitutionalization

Deinstitutionalization

The General Atmosphere at the Hospital

- The Blair Report came out during the 1960s and is seen as having significantly influenced developments at the hospital. Could you describe what the hospital was like before the report was commissioned: the general atmosphere, treatment of the patients, the staff?

General

- What factors or conditions led to the development of the study?
- Were there particular reasons for its initiation?
- Who commissioned the study?
- How was the study conducted?
- Who were the committee members?
- How were they selected?
- What was the purpose of the study?
- In your opinion, was that purpose achieved?
- What were the findings of the report?
- How was the report published?
- How was it received in the hospital? And in the community?

Staff

- What was your response to this study?
- Did you participate in the study? How? How was your input received, and how did it appear in the report?
- What was the effect of the report on you as a staff member?
- What was the staff's general reaction and response to this report?

Hospital

- How was the study perceived by officials of the hospital?
- What were its effects on the day-to-day operation of the hospital?

- Did anyone in particular provide leadership in the hospital toward implementing its recommendations?
- Were there any resistors?
- What form did resistance take?

General

- Were there pressures on the government to make changes based on the findings of the report?
- Were there particular government officials who agreed with the findings in the report? What form did this support take?
- Were there any opposing views or resistance by government officials?
- How did the support and/or resistance affect the implementation of the recommendations?